DISSERTATION ON

"A STUDY TO ASSESS THE PERCEPTION AND ACCEPTANCE OF TREATMENT BY IMPAIRED FERTILITY AMONG MALES ATTENDING INFERTILITY CLINIC AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY, CHENNAI-8".

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In partial fulfillment of the requirements for the degree of

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APRIL-2012

CERTIFICATE

This is to certify that this dissertation titled, **"A STUDY TO ASSESS THE PERCEPTION AND ACCEPTANCE OF TREATMENT BY IMPAIRED FERTILITY AMONG MALES ATTENDING INFERTILITY CLINIC AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY, CHENNAI-8"** is a bonafide work done by **Mrs.S.Vahitha,** College of Nursing, Madras Medical College, Chennai-03, submitted to The Tamilnadu Dr. M.G.R. Medical University, Chennai-32 in partial fulfillment of the university rules and regulations towards the award of the degree of Master of Science in Nursing. Branch-III, Obstetrics and Gynaecological Nursing under our guidance and supervision during academic period from 2010-2012.

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ABSTRACT

A descriptive study was aimed to assess the perception and acceptance of treatment for impaired fertility among males attending Infertility Clinic at IOG, Chennai-8**.** Fertility has been one of men's desired attributes since the beginning of recorded history and still remains a driving need for young couples today. The cases of infertility can be extremely simple or very complex.. Men are directly responsible for about 30-40% of infertility. One of the most difficult aspects of primary infertility treatment for the couple is to decide when to stop. Because infertility treatment processes often involves repeated therapies and creates further stress and disappointment. The aim of the study is to assess the perception and acceptance of treatment for impaired fertility by infertile men and to associate them with selected demographic variables. Quantitative descriptive approach design was used. The study was conducted in the Infertility Clinic at the Institute of Obstetrics and Gynaecology, Hospital for Women and Children, Chennai-8. 150 men were selected as the study subjects by convenient sampling. The tool used for the study was Rating Scale and Structured Questionnaire. This study assessed the perceptions and acceptance of treatment towards the male infertility. There was a positive moderate relationship ($P<0.05$) between perception and acceptance of treatment by infertile men. The study concluded that majority of the men perceived moderate level of perception but are irregular in accepting the treatment towards the infertility.

CHAPTER – I
1.INTRODUCTION

The basic function of the living organism is its capacity to reproduce its own kind. Fertility has been one of men's desired attributes since the beginning of recorded history and still remains a driving need for young couples today.

Osler, W., (1991) stated that human beings have two basic desires "to get" and "to be got". To have one's own family is a universal dream. This dream is more longed for by the infertile couple. Infertility problem can cause pain and difficult emotions. More recently Enrich and McGrath have described infertility as "chronic sorrow".

Infertility is a serious medical concern that affects quality of life and is a problem for about 10% of the reproductive age population (American Society of Reproductive Medicine ASRM 2002). Infertility implies subfertility, a prolonged time to conceive, as opposed to sterility which means inability to conceive. Normally a fertile couple has approximately 20% chance of conception in each ovulatory cycle.

But failing to become parents, to go through the cycle of life that most of us assume will be automatic, can have devastating consequences for both the adults involved. To find that the life we expected to have, and the way in which it would evolve has been taken away is emotionally fraught. It can test the love and devotion of any couple when they face with the stark reality that their happy union will not result in another life and that it might be restricted to just two of them rather than blossoming into a larger family.

The prevalence of infertility is relatively stable among the over-all population but increases with the age of women particularly in those older than 40 years ***(Stench ever, et al., 2001)***. Diagnosis and treatment of infertility require considering physical, emotional and financial investment over an extended period. Men and women often perceive infertility differently, with women having more stress from tests and treatments, play

greater importance in having children, accepting more of indicated treatments and wanting children more than men.

When couples fail to conceive, the attention and support is invariably focused on the women. The greatest loss is assumed to be felt by the women who will never be able to carry a baby and give birth as she hoped. There is no doubt that the emotions attached to motherhood are unique and it would be churlish to deny that men and women react differently to both the prospects and the reality of having a child.

Generally, worldwide it is estimated that one in seven couples have problems in conceiving, with the incidence similar in most countries, independent of the level of the country's development.

Male infertility refers to the inability of a male to achieve a pregnancy in a fertile female. In human it accounts for 40-50% of infertility. Male infertility is commonly due to deficiencies in the semen and semen quality is used as a surrogate measure of male fecundity.

Health care providers can help couples with infertility by designing supportive services and offering psychological counselling. Interventions that provide educational information and teach new skills may produce positive changes than interventions which are focused solely on counselling and expression of feelings ***(Bovine, 2003).***

The cases of infertility can be extremely simple or very complex. Conception depends on the fertility potential of both the male and female partners. Men are directly responsible for about 30-40%, the factors are defective spermatogenesis, obstruction of the efferent duct system, failure to deposit sperm high in the vagina, errors in the seminal fluid, genetic and endocrine factors.

There is no longer any disagreement that infertility is a distressing experience. Between 1970 and 2000, the world population experienced a major and unprecedented reduction of fertility levels, driven mostly by the decline in fertility in developing countries dropped from over 5.9 children per

woman in the 1970's to about 3.9 children per woman in the 1990's. The median fertility reduction in developing countries between the 1970's and the 1990's was of the order of 1.8 children per woman and a quarter of all developing countries appear to have achieved reductions of 2.6 children per woman or more.

One of the most difficult aspects of primary infertility treatment for the couple is to decide when to stop. Because infertility treatment process often involves repeated therapies and creates further stress and disappointment and finally the couple are obliged to share intimate endings of sexual behavior. The range of treatment is available which means that if one treatment fails, then another area can be tried, therefore it can result in endless cycle of treatments with disillusionment and despair at the end of it. Many couples are prevented by the idea that every that next treatment may be successful and make the decision to either remains childless or supply for adoption alternatively ***(Myles)***.

Infertility can have profound effects on sexual relationships. Frequent sources of stress are the money procedures involved in infertility workup and the need to engage in sexual intercourse on schedule and the repeated cycle of raising hopes followed by disappointment.

Irrespective of who the infertile person, it is the woman who usually initiates the first contact with the physician. Couples with primary infertility are usually more interested in treatment than those of with secondary over a long period. Treatment sometimes continues over a longer period, for example, women sought allopathic treatment for 25 years and some continue to rely on rituals or religious practices for over 30 years.

Because infertility is essentially a shared experience, examining couples from a family system's perspective can increase the knowledge of the emotional complexity of infertility and enable nurses to develop interventions that foster communication and understanding between the couple.

Infertility can lead feelings of loneliness and isolation and can create a great strain in the marital relationship. Nurses need to understand

their feelings and the stress so that they can better intervene in the case of their patients and help them to cope with their infertility.

Identifying treatment seeking behaviour helps in educating the infertile men to go for proper treatment procedure, which ultimately results in effective treatment outcome. Advances in science have come certainly, especially in the field of obstetrics. Infertility is no more the objectionable word in society. The fertility of men is also no longer much of a concern now a day with advanced technology: it is now possible to reproduce by means of assisted reproductive technology.

There are many reasons, among which some are unknown in the case of infertility. In emotionally charged times guilt and anger boil up and it takes a great deal of strength and courage to rise above these destructive feelings.

1.1 NEED FOR THE STUDY

Infertility is a major life crisis for any couple or individual. Infertility and its treatment are extremely stressful, causing serious psychological reactions such as anxiety, depression, social isolation, sexual problems, marital discord and feelings of unworthiness. In turn, these reactions will negatively influence an individual's personal, interpersonal, social and occupational functioning.

Nevertheless, it is believed that at least 50% of infertility is caused by male factors, such as deficiencies in sperm production and blockages in the sperm delivery system. Specifically, statistics show that 33% of problems can be traced directly to male fertility, 33% to pure female-factor infertility and 33% to a combination of male- and female-factor infertility. However, historically more attention has been focused on treating female infertility than male factor problems. One reason for this is the number of specialists that practice reproductive medicine. The American Society of Reproductive Medicine (ASRM) reported that in 2007, 65% of its membership constituted of obstetricians and gynecologists, whereas less than 10% were urologists or andrologists. Typically, male infertility treatment has been circumvented rather than treated directly. Examples would include using donor sperm with insemination, or combining Intracytoplasmic Sperm Injection with

Invitro fertilization, for which only one living sperm is required per egg.

The psychological literature has paralleled this pattern of ignoring male- related issues and has focused more on the emotional squeals of women's responses to infertility. This is partly due to the fact that women are perceived to experience greater losses (such as gestation, birth and breast feeding) during infertility than men. Furthermore, in stressful treatment processes such as Invitro Fertilization, most of the difficult procedures like egg collection and hormonal injections fall on the female. In addition, socio-biological theory proposes mothering as more integrated to a woman's identity and physiological needs than fathering is to a man's identity.

Assessing how well a person or a couple is coping with infertility is an essential part of the domain of nursing, and helping people to cope with emotional and psychosocial aspects of infertility.

WHO estimates that approximately 8% to 10% of couples experience some of a infertility problem. On a worldwide scale, this means more than 50-80 million people suffer from infertility. The incidence of infertility in men and women is almost identical. Infertility is exclusively a female problem in 30-40% of cases and male 10-30% of cases (WHO, 1980).According to reports from infertility clinics, the prevalence rate of infertility in Tamilnadu is 10 – 15%.

Table: 1 Infertility statistics at Institute of Obstetrics and Gynaecology, Chennai-8. From 2006-2011

YEAR	OLD CASE	NEW CASE
2006	6480	1038
2007	5467	1013
2008	4208	780
2009	3977	834
2010	5300	900
2011 up to September	4321	765

The above table reveals that there is not much difference in declining the number of new cases attending Infertility Clinic.

Although most of the study reveals that male participation in infertility diagnosis and treatment tends to be limited as infertility is perceived to be a women's problem, in some contexts, husbands also participate and accept treatment is required.

During the clinical exposure, the researcher came to access many infertile couple who are facing one or more of the emotional problems. This motivated the researcher to assess the perceptions and acceptance of treatment by infertile men in order to capture complex human behavior of primary infertile men.

1.2 STATEMENT OF THE PROBLEM

Assess the perception and acceptance of treatment for impaired fertility among males attending Infertility Clinic at IOG, Chennai-8.

1.3 OBJECTIVES

1) Assess the perception experienced by infertile men.

2) Assess the acceptance of treatment by infertile men.

3) Find out the association between perceptions and selected demographic variables.

4) Find out the association between acceptance of treatment by infertile men and selected demographic variables.

1.4 HYPOTHESIS

H_1 There will be a significant association between the selected demographic variables and perceptions experienced by infertile men.

H_2 There will be a significant association between selected demographic variables and acceptance of treatment by infertile men.

1.5 OPERATIONAL DEFINITION

Impaired Fertility

Impaired fertility is defined as the inability to conceive and carry a pregnancy to viability after at least one year of regular sexual intercourse without contraception.

Perceptions

Refers to the subjective experience of the infertile men due to the various perceived factors which are expressed verbally in response to the rating scale prepared. They are classified into physical, psychological and sociological perceptions.

- Physical perceptions includes weight reduction, lack of appetite, tension headache etc.
- Psychological perceptions include irritability, anger, crying spells, insomnia etc.
- Sociological perceptions includes lack of family support, hesitate to attend family functions, restricted pleasure trips etc.

Acceptance of treatment

They are the actions which are followed by infertile men. The acceptance of treatment included in the study are sequential tracking, back tracking, taking a break, getting stuck and paralleling.

- Sequential tracking - in which men exhaust one option before considering another route to parenthood.
- Back tracking - in which men retry a medical regimen with a new physician.
- Taking a break – A withdraw from the treatment.
- Getting stuck - In a treatment groove.
- Paralleling – An attempt to pursue multiple options simultaneously.

1.6 ASSUMPTIONS

1) All infertile men experience some form of perception.

2) Infertility leads to social stigma.

3) Infertility can threaten men's identity, status and economic security.

4) The level of acceptance of treatment experienced by infertile men differs from man to man.

5) Men may delay seeking medical advice because of the fear of a final definite diagnosis, emotional stress, and the physical discomfort of the test they would have to undergo and admitting failure in the efforts to conceive.

1.7 VARIABLES

- Independent variable - Male infertility
- Dependent variables - Perceptions and acceptance of treatment

1.8 DELIMITATIONS

The study was delimited to men who

- Were suffering from primary infertility
- Attending Infertility Clinic at IOG, Chennai-8 from 29.8.11 to 29.911.

CHAPTER – II
2.REVIEW OF LITERATURE

"A great literature is chiefly the product of inquiring minds in revolt against the immovable certainties of nation".

-Mecken H.L.

A literature review involves the systematic identification, location, scrutiny and summary of written materials that contain information on a research problem ***(Polit & Hungler, 1999)***.

The review of literature in this chapter has been presented fewer than four broad headings.

- Incidence
- Factors of infertility.
- Perceptions of infertility by infertile couples.
- Acceptance of treatment or treatment seeking behavior among infertile couples.

2.1 INCIDENCE RELATED TO INFERTILITY

A community inquiry was carried out by ***Kumar (2007)*** in South Central of India on prevalence of female infertility and its socio economic factors in Tribal communities. The prevalence of infertility of the study population was 33(14.2) out of 232 women. In the Khairwars, infertility was found among women 23 (17.2) which are significantly higher than in non-Khairwars (10%). The mean age of infertile women among the Khairwars was 31.3+or – 8.9 years and 27.5+ or – 9.2years among non-khairwars. The average duration of marriage of infertile women in the Khairwars and non-khairwars was estimated as 14.9+ or – 7.7 yrs and 11.1 + or - 7.9yrs respectively. He concluded that the prevalence of infertility is higher in the Khairwars compared to non-Khairwars.

Infertility is the inability of a couple to achieve conception or to bring a pregnancy to term after a year or more regular unprotected intercourse. In an article titled "Is infertility a stress related world problem", **Dr. Rajeswari** highlights the WHO report of incidence of infertility (as cited in NNT 2006). It estimates that approximately 8-10% couples experience some form of infertility problems. This article explained that 50-80% million people suffer from infertility and the incidence of infertility in men and women is almost identical. It also mentions that infertility is exclusively a female problem 30-40% and for about 10-30% is due to male problems.

US census bureau (2004) estimated the extrapolated prevalence of infertility of various countries and regions. In India, the prevalence of infertility was 23,885,775 among the estimated population of 1,065,070,607.

An article in the Hindu was published by ***Nandita (2002)*** that incidence of infertility is about 15-20% in India, 30% of the chances are that of it is due to men,30% of it could be due to women and sometimes 30% of it could be due to both partners. In Tamilnadu, 12-15% of present day couples meet with the problem of infertility.

Stench ever et al., (2001) reported that the female factor such as ovulatory or pelvic factor is responsible for infertility in about 50% of infertile couple (ASRM, 2002). Male factor (sperm and semen abnormalities) is responsible for infertility in about 35% of couples. Unexplained factors and unusual causes related to both partners are responsible for 15% of infertility.

Globally the incidence of infertility was 13-18% in human population regardless of race, ethnic group etc (***Thonnen et.al,)***. Among this 67-71% have primary and 29-33% of patients have secondary infertility problems respectively. Normally a fertile couple has approximately 20% chances of conception in each ovulatory cycle and infertility affects about 10-15% of reproductive aged couples. **(Nelson and Marshall 2004)**

2.2 FACTORS RELATED TO INFERTILITY

Liu Y, Lin H et al., (2010) conducted a study to identify the association between socio-psycho-behavioral factors and male semen quality. They took thirteen socio-psycho-behavioral factors in 57 cross-sectional studies with 29,914 participants from 26 countries/regions. The results showed that smoking can deteriorate all the sperm parameters of both fertile and infertile men, but it is not risk factor for semen volume in Switzerland and Iran and for sperm density in the United States, Denmark, and Brazil; higher age and alcohol consumption are risk factors for lower semen volume; and psychological stress can lower sperm density and sperm progressive motility and increase abnormal sperm. The authors concluded that high age, smoking, alcohol consumption, and psychological stress were risk factors for semen quality. These results indicated that health programs focusing on lifestyle and psychological health would be helpful for male reproductive health.

In Egypt 2010, ***El-Helaly M, Awadalla et al,*** from Department of Public Health and Preventive Medicine, Faculty of Medicine, The University of Mansoura, conducted a case control study on "Workplace exposures and male infertility". This study was carried out from January 2008 to February 2009. 255 infertile men and 267 fertile men who are working a certain occupational exposure to chemical, physical and psychological workplace hazards were assessed by self-report questionnaire. The results revealed that workplace exposure factors significantly increased the risk of male infertility. The author concluded that this study supports other studies that raise the attention to minimize the exposure to the workplace hazards that may affect the fertility of male workers.

Natali A, Turek PJ, (2010) conducted a study to the assessment of New Sperm Tests for Male infertility. The routine analysis, although used for more than 50 years, fails to accurately distinguish between fertile and infertile men. As a consequence, many tests of sperm function (TSF) have been developed. This review discusses both older and newer diagnostic TSF. It

outlines the principles underlying each assay and reviews aggregate clinical data to determine its current relevance and utility. The study concludes that the relevance of many older TSF is questionable, with the wide acceptance of intracytoplasmic sperm injection.

In Pakistan**, *Dr.Tobba Mehrannia,(2007),*** conducted a study to assess the effect of cigarette smoking on semen quality of infertile men. 200 infertile men who had been smoking cigarette and 130 infertile nonsmokers' men participated in this study. Seminal volume, sperm concentration, motility, viability and morphology were examined. The quality of spermatozoa obtained from smokers was much lower than nonsmokers ($P < 0.01$). The sperm concentration, viability and forward progression were negatively correlated with cigarette smoking ($P < 0.01$).

Olivia.A & Spira. A (2001), *U.K.* conducted a study on "contribution of environmental factors to the risk of male infertility" with the sample of 225 male partners. The objective was to investigate the relationships between exposure to environmental agents and seminal characteristics of reproductive hormones in the serum of men experiencing conflict over their feminity and fear associated with reproduction. Emotional factors may negatively affect male infertility. The more obvious effect of the emotional stress in infertility among male is the occurrence of impotence. Infertility is frequently perceived by the couple as an emotional strain, and counseling may prove helpful.

Chaise & Limst,(2000) conducted a case control study in USA to identify the "factors associated with male infertility" in 218 infertile and 240 fertile men in department of Obstetrics and Gynaecology. Result of the study revealed that semen parameter of all cases was significantly poorer than that of the controls. The significant factors predicting infertility were smoking, density of sperm, and viability of sperm. Smoking increased the odds of being infertile. Higher sperm counts and larger percentage of viable sperm decreases the odds of infertility. Density of sperm and the viability of sperm are significant predictors for infertility among men.

Falzone N, Huyser.H et al., Department of Biomedical Sciences Tshwane University of Technology, South Africa published the article of "Mobile phone radiation does not induce pro-apoptosis effects in human spermatozoa". The authors suggest that mobile phone radiation may diminish male fertility. However, the effects of these human spermatozoa are largely unknown. The present study examined effects of the radiation on induction of apoptosis-related properties in human spermatozoa. Ejaculated, density-purified, highly motile human spermatozoa were exposed to mobile phone radiation at specific absorption rates of 2.0 and 5.7 W/kg. The authors concluded that the mobile phone radiation had no statistically significant effect on any of the parameters studied. This suggests that the impairment of fertility reported in some studies was not caused by the induction of apoptosis in spermatozoa.

Ebomoyi and Adetoro (1990) conducted a descriptive study to assess the social biological factors influencing infertility in a rural Nigerian community. The study revealed a prevalence rate of 12.9% primary infertility and 54.1% of secondary infertility. Age, education and religion of respondents has statistically significant influence on infertility ($p<0.05$) but not income ($p>.0.05$). The correlation between age of respondents and infertility was statistically significant ($p<0.05$). They suggested that the primary health care efforts aimed at implementing maternal and child health care should explore the traditional customs on infertility in rural areas of developing countries.

2.3 PERCEPTIONS OF INFERTILITY BY INFERTILE COUPLES

Juliana Rigol Chanchamovich et al, **(May 2010)** conducted study on "Agreement on Perceptions of Quality Of Life in Couples Dealing with Infertility" in assisted reproduction clinic of a University Hospital, and study participants are 162 couples. The men's and women's mean age were 36.1 and 32.1years respectively. Most participants had no children, and no previous assisted reproduction attempts. Men and women completed the World Health Organization-Quality of Life-Brief and the Beck Depression Inventory

independently. Findings indicated little agreement in perceptions of the partner's QOL, with each partner tending to underrate the other's view. Practitioners need to consider the differences between partners to enable partners to better understand and support each other.

Jane Bainbridge and Laura Peronace (2010) published the study of male infertility and emotional wellbeing with 256 men who were selected from the Copenhagen Multi-centre Psychosocial Aspects of Infertility research programme. The questions were completed before the start of treatment and again a year later if no pregnancy had resulted from the treatment. The results were analyzed by splitting the men into four groups: those with unexplained infertility, female infertility, male infertility and a mix of both. The study showed that social stress, marital stress, coping effort and physical stress all increased over time and mental health decreased. But of most interest were that all the men, regardless of the reason for the infertility, suffered equally.

Vaidhyanadan, R, et. al. (2006) stated that stress a buzzword of the 90s is in every day of life at one point, or everybody suffers from stress. Infertility is a chronic illness that uses a large amount of a couple's resources (emotional and financial) and involves the expenditure of a considerable amount of time, money and physical and emotional energy.

In Greece ***Maria Ketsardi, (2006),*** conducted a exploratory and quantitative study on psychosocial problems of infertile people with 60 individuals (43 women and 17 men) with history of infertility (diagnosed 1-5years) of mean age of 34 years (34+or-5), married, well educated, with no children at all, were participated in this study, and they answered 20 multiple choice questions included in the questionnaire, which was administered. The psychological and social needs are not adequately addressed within the framework of such a medical model. According to results severe psychosocial problems impact the everyday life mostly the men (74%) of an infertile couple that include feeling of stress (35%), angry (20%) and guilty for the infertility.

In Southern Iran, ***Ashkani H. & Akbari. T, (2006)*** conducted a study on epidemiology of depression among infertile and fertile couples. This study investigated psychological factors thought to be associated with perceived stress over the course of infertility treatment. The research was based on the secondary analysis of data from the study of marriage, family and life quality with sample of 128 people who completed infertility related stress instrument. Self esteem and perceived health was associated with stress. Importance of biological family and extent of spousal support are important factors in stress reduction

In India, ***Peterson BD, (2003),*** conducted a study on examining congruence between partners' perceived infertility related stress and its relationship to marital adjustment and depression in infertile couples. Couples referred for infertility treatment at a University affiliated teaching hospital. The purpose of the study was to explore the impact of congruence between partners's perceived infertility related stress and its effects on depression and marital adjustment in infertile men and women. Study finding showed that men and women who are couples perceived equal levels of social infertility stress reported higher levels of marital adjustment when compared to men and women who are couples, who perceived the stress differently. In addition woman among couples who felt similar need for parenthood reported significantly higher levels of marital satisfaction when compared to women in couples where the males reported a greater need for parenthood.

In India ***Hirsh A.M. & Hirsh S.M (2003),*** conducted a study on long term psychosocial effects of infertility. The aim was to explore the psychological effect of infertility and the role that social support plays over time. Setting was participant's own home. Four questionnaires were answered one in every 9 months. 94 subjects were participated in the study. Main outcome measures were marital satisfaction, sexual satisfaction, self esteem, sex role identity pressures and social support. The results were infertile couple's experiences increased social support and greater contentment overtime. The positive impact of social support, counseling and the adoption of strategies to deal with the stress infertility lends credence to the crucial

role for nurses can play in helping infertile couples to cope.

A.Piero & Boggio,(2002) India, conducted a controlled study on anxiety, depression and anger in infertile couples with 156 infertile couples and 80 fertile couples, whose personal characteristics were recorded. They were examined using scales for the evaluation of the degree of psychopathology. The 156 infertile couples were than subdivided into groups based on the cause of infertility. The psychometric evaluation was double-blind with respect to the causes of infertility differences emerged in the degree of psychopathology between 'organic' and functional infertile subjects and fertile controls. The 'functional' infertile subjects of this sample showed particular psychopathological and psychological features, independent from the stress reaction following the identification of the cause of infertility.

T.Y & G.H. Sun., (2001), Taiwan conducted a study on the effect of an infertility diagnosis on the distress, marital and sexual satisfaction between husbands and wives in Taiwan. The study showed that no differences are marital and sexual satisfactions were found between wives and husbands with unexplained infertility. Only wives with a diagnosed female infertility expressed higher distressed to infertility than their husbands. Although no differences in psychosocial responses were found among husbands, regardless of the diagnosis, wives with a diagnosed female infertility experienced higher distress low self esteem and less satisfaction in acceptance by in-laws than wives experiencing a diagnosed male infertility. These findings suggested that the diagnosis of infertility is an important factor in assessing the differences in infertility distress and marital and sexual satisfaction between husbands and wives.

In China, ***Dhillon.R & Cumming, (2000),*** conducted a cross-sectional study on psychological well-being and coping patterns in infertile men in a Hospital based academic fertility and the samples were 30 fertile men with currently pregnant wives, 30 euspermic and 30 oligoasthenospermic men in couples undergoing ovulation stimulation. Measures of psychological well-being and coping were administered. The study showed that there were

no significant differences among the groups on any of the measures except the Family Inventory of Life Events in which fertile men reported higher stress levels. This study suggests that men's psychological adjustment to their own infertility and to unexplained infertility is generally healthy.

In Thailand ***Seibel .MM & Taymora M.L, (2000),*** conducted a study on "Emotional aspects of infertility". The psychological aspects of infertility in both men and women are reviewed, and awareness of stresses that infertility places' on a couple's relationship is encouraged. Studies have found that infertile women to be more neurotic, dependent and anxious than fertile women experiencing conflict over their feminity and fear associated with reproduction. Emotional factors may negatively affect the male infertility. The more obvious effect of the emotional stress in infertility places on male is the occurrence of impotence. Infertility is frequently perceived by the couple as an emotional strain, and counseling may prove helpful.

Wright. J Lecours,(2000) *USA* conducted a study on psychosocial profile of couples with 30 couples consulting fertility clinics. Analyses of results showed that the psychosocial profile of subjects consulting fertility clinics is midway between that, as normal subjects and that of individual suffering from psychological problems. By using multiple regression analysis the researcher has identified several psychosocial problems such as depression, self esteem and stress.

Xu. L & Ke. Hx,(2000) *China* conducted a prospective study on psychological aspects of infertility due to various causes. Subjects and methods of the study were one hundred and twenty infertile couples and 30 fertile couples as controls were evaluated for psychological assessment by different psychological test instruments. Initial evaluation was done at recruitment, followed by reassessment at 3, 6, 9 and 12 months during the infertility work-up, and at the end when the specific diagnosis and the management and prognosis were disclosed. The results showed that psychological components were found to play a significant role in infertility of unknown etiology, especially in the male partner. They affected the

personality and social behavior of the male partner and caused anxiety, but led to depression in the female partner. Anxiety was significantly greater in the partner with the fertility problem than in the other partner. Life events were significant in the partner in whom the fertility problem was detected. Depression and anxiety in the female partner were evident soon after the investigation started.

Christopher, R.N et. Al., (1999) stated that infertility has been characterized as creating a form of chronic stress that can give one to a variety of psychological difficulties. More recently published evidence suggests that stress itself may influence the outcome of infertility treatment

In 1999 Dasgupta, Chen and Krishnan stated that infertility is a life crisis with invisible loses and its consequences are manifold. Childless women have experienced stigma and isolation. Infertility can threaten a woman's identity, status and economic security and consequently, be a major source of anxiety leading to lowered self esteem and a sense of powerlessness. Although perceptions of men's role and attitudes may be shifting, particularly in the upper and middle classes, bearing a child still remains an important factor in the socio-economic well being of the most Indian Men.

Connolly. K. J.,(1999), *UK,* conducted a study on impact of fertility on psychological functioning. The results showed little evidence of psychopathology in the sample; depression scores remained low throughout the period of investigation. The results also indicated stable marital relationships. Scores on tests of anxiety and psychiatric morbidity declined between the first and second assessment except in the case of men who were diagnosed with a fertility problem.

In India ***Wright J. Duchense, (1999),*** conducted a study on psychosocial distress and infertility, men and women respond differently. The purpose of this study was to evaluate greater differences in psychosocial responses of 449 consecutive first admission couples in a fertility clinic. Consistent with previous research, infertile women showed higher

distress than their partners on a global measure of psychiatric symptoms and subscales of anxiety, depression, hostility and cognitive disturbances, as well as on measures of stress and self esteem. When compared with same sexed population norms on the measure of psychiatric symptoms, both male and female infertile patients were significantly more distressed than average. No evidence was found for unusually high levels of marital or sexual distress at intake. Implications of results for clinical management are explored.

Nieuwenhuis SL, Odukogbe AT et al., conducted an explorative and qualitative study to assess the impact of infertility on infertile men and women in Ibadan, Nigeria. This study explored the impact of infertility on infertile men and women in Ibadan, Nigeria and included the application of focus group discussions with community members, in-depth interviews with infertile men, infertile women and professionals. The findings revealed that infertile men and women and community members commonly perceived that contraceptives and abortion cause infertility, as well as supernatural and behavioral factors. The authors concludes that efforts to reduce the impact should prioritize education on the causes, prevention and treatment of infertility, offer psychological support and ensure an efficient referral system for managing infertility.

Andrews F.M & Abeey. A, (1999), *UK* conducted a study to identify whether fertility problem is stress different- the dynamics of stress in fertile and infertile couples to compare the dynamics of fertility problem stress experienced by wives and husbands in infertile couples with the dynamics of stress from other sources experienced by members of couples presumed to be fertile. Face to face interviews were conducted in study participant's homes. Wives and husbands from 157 couples with primary infertility and from 82 presumed fertile couples were studied. Intervening outcome scales measured four marriage factors marital conflict, sexual self esteem, sexual dissatisfaction and frequency of intercourse. Higher levels of stress, regardless of whether those stresses were from attempting to solve fertility problem or another problem, were related to reduce marital functioning and decreased life quality.

2.4 ACCEPTANCE OF TREATMENT SEEKING BEHAVIOUR AMONG INFERTILE COUPLES

Hwang K. et al., (2007) published the article of contemporary concepts in the evaluation and management of male infertility and it was says that at the core of the medical evaluation of the male partner in a couple who are unable to conceive is the history and physical examination. Special attention should be directed to the patient's developmental history and any use of testosterone products. The physical examination focuses on the genitals, and includes assessments of the size and consistency of the tesicles, epididymis, vas deferens, and presence of varicoceles. Although many sophisticated tests are available, semen analysis is still the most important diagnostic tool used to assess fertility, and includes parameters such as sperm count, motility and viability. Treatment of male factor infertility can involve targeted agents, in the case of specific conditions such as hypogonadotropic hypogonadism, or it can be empirical-using medical therapy or assisted conception techniques for patients in whom no underlying cause has been identified. Although an all-encompassing treatment for male factor infertility has not yet been developed, the field offers many promising avenues of research

Dyer et al., (2004) had done a study on experiences, reproductive health knowledge, and treatment seeking behavior among men suffering from couple infertility in South Africa with 27 men from a diverse cultural urban community in South Africa participated in in-depth interviews at the time of their visit to an infertility clinic in a tertiary referral centre. The study showed that men have little knowledge and the physiology of human infertility, causes of infertility and modern treatment options. Men described their emotional reactions to childlessness and their impact of infertility on a marital stability, and May reported that infertile men suffered from stigma ion, verbal abuse and loss of sound status. They concluded that the findings will improve our understanding of reproductive health needs of men suffering from infertility in Africa. This understanding is essential for effective integration of male partners in to modern infertility management.

Kurerova M, et al., (1997) conducted a study of attitudes and psychological opinions of infertile couples by anonymous questionnaires conserved separately by men and women. The majority of the couples prefer assisted reproduction to adoption and they accept all varieties of these techniques. The opinion of men and women did not differ greatly.

Van Empel IW, Aarts JW et al., conducted a study on measuring patient-centeredness', the neglected outcome in fertility care: a random multicentre validation study with 54 infertile patients. This study aims to develop and validate an instrument that can reliably measure patient-centeredness in fertility care: patient-centeredness questionnaire-infertility (PCQ-infertility). The PCQ's content, addressing 53 care aspects, was generated by seven focus groups. The questionnaire was completed by 888 infertile couples from 29 clinics. The ultimate PCQ-infertility, comprising 46 items and seven subscales, appeared reliable and valid for measuring patient-centredness in fertility care. Of the seven subscales, 'communication' received the best ratings and 'continuity' the worst. 'Honesty and clearness on what to expect from fertility care' appeared most important to patients. Significant differences between clinics were found, even after case-mix adjustment. This study resulted in a valid, reliable and strongly discriminating instrument for measuring patient-centeredness' in fertility care. The PCQ-infertility can identify shortcomings on patient-centeredness and can be adopted for quality improvement.

In the year *1992* ***Blenner*** conducted in-depth interviews of 25 infertile couples covering the full range of infertility etiologies and treatments were conducted in this qualitative study. Professional competence, sensitivity and environmental comfort acted as mediators increasing or decreasing treatment stress. In addition, couples individually or collectively action or developmental strategies to mitigate stress. High stress, lack of hope, and frustrations led to contemplation of terminating treatment.

2.5. CONCEPTUAL FRAMEWORK

A frame work is the conceptual under planning of the study. The investigator has developed conceptual framework based on Hildegard E. Peplau's interpersonal theory. According to Peplau, nursing is therapeutic, in that it is a healing art, assisting an individual who is sick or in need of health care. Nursing can be viewed as an interpersonal process; it involves interaction between two or more individuals with a common goal.

In interpersonal theory, there are four stages

- ❖ Orientation
- ❖ Identification
- ❖ Exploitation
- ❖ Resolution

ORIENTATION

In the initial phase of orientation, the nurse and the patient meet as strangers. The patient or family has a felt need, therefore professional assistance is sought. In this study, the respondents and the researcher meet as a complete stranger and maintain good interpersonal relationship.

IDENTIFICATION

Throughout the identification phase, researcher has to maintain therapeutic relationship with the patient. Both the patient and the nurse clarify each other's perceptions and expectations. In this phase the researcher identifies the perceptions and acceptance of treatment related to their infertility.

EXPLOITATION

Exploitation phase is a planning phase. In this phase, the researcher maintains therapeutic relationship with the patient and plan to administer demographic questionnaire, rating scale and structured questionnaire

regarding perceptions and acceptance of treatment. In this phase the researcher has to make solutions to rectify the problem.

RESOLUTION

In this phase, the need of the patient has been collaboratively met by the efforts of nurse and patient and this is the time for the nurse and the patient to terminate the relationship. In this study after maintaining therapeutic relationship with the patient, the researcher terminates the relationship with the patient.

FIG-1: CONCEPTUAL FRAMEWORK

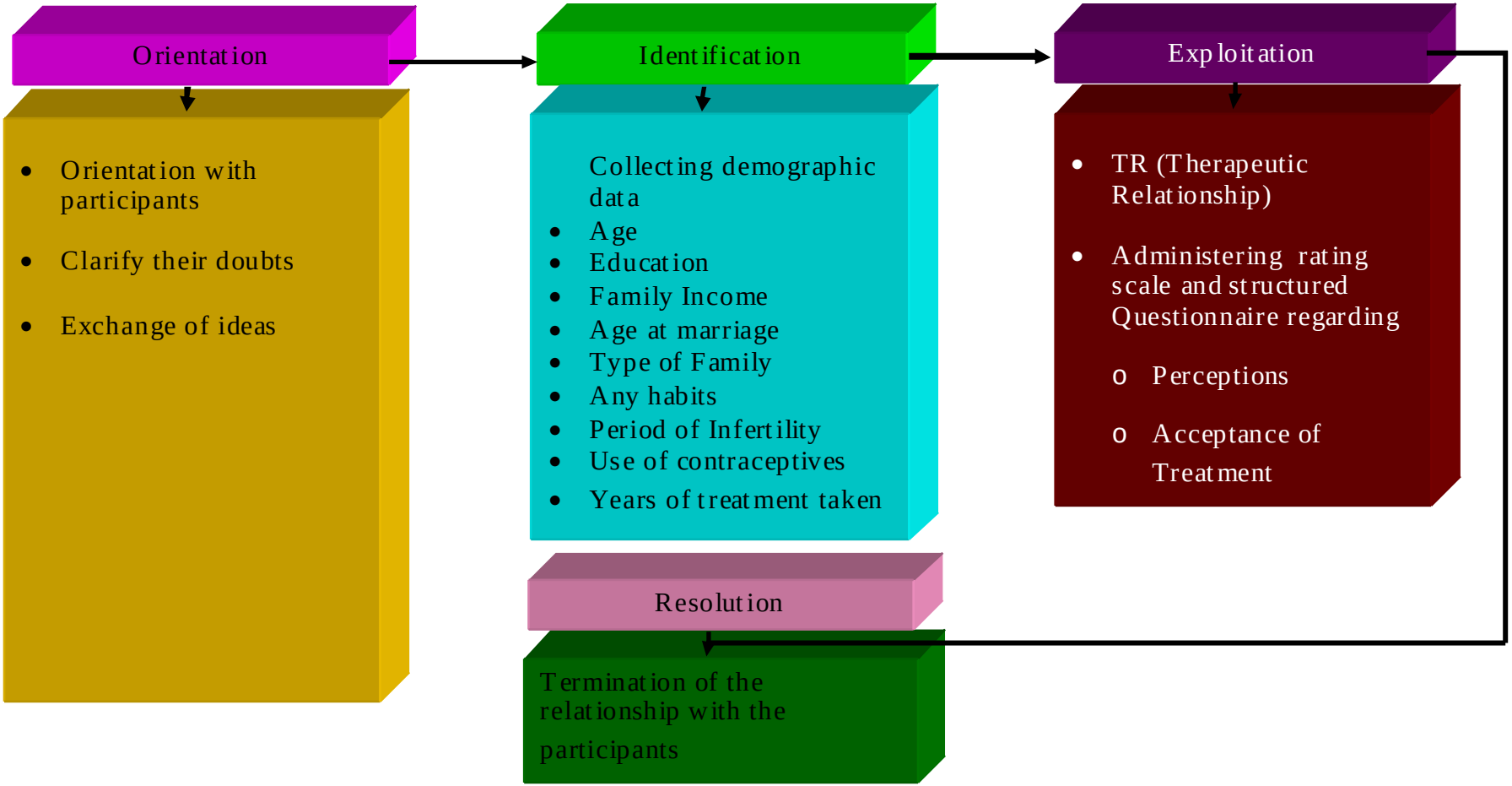


FIGURE: 1 MODIFIED HILDEGARD E.PEPLAU'S INTERPERSONAL THEORY

CHAPTER - III
3.RESEARCH METHODOLOGY

Research methodology is a way to systematically solve the research problem. It is a set of methods and principle used to perform a particular activity. It is the most important part of any research study, which enables the researcher to form the blue print for the study undertaken.

This chapter deals with the methodology adopted for the study which include description of the research approach, research design, setting, development and description of instrument and different steps used for collecting and organizing data are stated below.

3.1. RESEARCH APPROACH

Research approach is the most significant part of any research. The appropriate choice of research approach depends upon the purpose of the research study; which was undertaken. The approach to research is umbrella, which covers basic procedure for conducting research.

Quantitative descriptive approach was used to assess the perceptions and acceptance of treatment by infertile men.

3.2 RESEARCH DESIGN

Descriptive study design was used for this study.

3.3 SETTING OF THE STUDY

The setting for the study was Institute of Obstetrics and Gynecology, Govt. Hospital for Women and Children, Chennai-8. This institute was unveiled on 26th July 1844 for public service. It is 752 bedded hospitals catering to the needs of poor and needy serving at least 33120inmates per year and average of 18000 per year. It is one of the research institutes in which all types of research concerning with the health of the reproductive age group people being carried out. There are nearly 40-50 couples are attending infertility clinic every day for treatment and follow up care and average of

400-500 patients are attending Infertility Clinic per month. This institution has the facility to investigate with semen analysis for male patient, ultrasound, laparoscopy, hormonal levels, and follicular studies for female patients regularly.

3.4 POPULATION

Population refers to totality of all the subjects, objects or members that conform to a set of specification ***(Polit & Hungler, 2005)***.

The target population of the present study was primary infertile men who are attending the Infertility Clinic at Institute of Obstetrics and Gynecology, Chennai-8.

3.5 SAMPLE

Infertile men who met the inclusion and exclusion criteria were taken as the sample during the study period. That includes 150 men who were already diagnosed as primary infertility men and those who have taken irregular treatment.

3.6 SAMPLE SIZE

150 infertile men were included in the study.

3.7 SAMPLING TECHNIQUE

Convenient sampling technique was used to collect data from the infertile men who are diagnosed as primary infertility.

3.8 CRITERIA FOR SELECTION OF SAMPLE

Inclusion Criteria

- Men who are between the age group of 20-40yrs
- Men who are married and staying with their spouse
- Men who are attending the infertility clinic with the diagnosis of primary infertility

- ❖ Men who have undergone any type of infertility treatment
- ❖ Who are willing to participate in this study
- ❖ Who speak Tamil and English

Exclusion Criteria

- ❖ Secondary infertility clients are excluded from this study
- ❖ Men with co morbid illness are excluded.

3.9 DEVELOPMENT AND DESCRIPTION OF THE TOOL

A tool is a written device that a researcher uses to collect data. Instrument consists of demographic data pertaining to the infertile men and rating scale and structured questionnaire to assess the perceptions and acceptance of treatment by infertile men.

METHOD OF DEVELOPING TOOL

The tool consists of three sections:

Section I: This includes demographic data which consists of age, education, occupation, type of family, duration of infertility and years of treatment taken for infertility etc.

Section II: consists of rating scale to assess the perceptions

The rating scale is designed to assess the level of perceptions which was developed by the researcher which extends from never to always. It includes the various aspects of infertility concerns like physical concern, psychological concern and social concern. The perception scores are classified into four levels.

Scores	Level of perception
0-23	No perception
24-46	Mild
47-69	Moderate
70-93	Severe

Section III: consists of structured questionnaire to assess the acceptance of treatment behavior by infertile men.

Structured questionnaire was used to assess the acceptance of treatment behaviour of infertile men. The structured questionnaire was framed very carefully, considering the language, clarity, organization and sequence of items.

A questionnaire was developed by the researcher to identify the type of acceptance of treatment behaviour by infertile men. The scale consisted of 25 items, to measure the behaviour of sequential tracking, back tracking, taking a break, getting stuck, paralleling with five items in each respectively. The responses were marked on a scale with scores of 3 2 1 and 0 respectively. The type of acceptance of treatment behaviour was attributarily divided into four levels.

Scores	**Level of acceptance**
0-18	Regular
19-37	Less Regular
38-56	Moderate Irregular
57-75	Highly Irregular

3.10 TESTING OF INSTRUMENT

CONTENT VALIDITY

In order to measure the content validity, the tool was given to two experts in the field of Obstetrical and Gynaecological Nursing Department. Experts judged the item for clarity, relevance, comprehensiveness and appropriateness of the tool. Suggestions made by experts were included in the framed tool and then used for pilot study to assess the reliability of the tool.

RELIABILITY

The reliability refers to the accuracy and consistency of measuring tool. After pilot study, reliability of the tool was assessed by using Split half method. Reliability correlation coefficient value is 0.82. This correlation coefficient is very high and it is good tool for assessing perceptions and

acceptance of treatment for impaired fertility among males attending infertility clinic.

3.11 ETHICAL CONSIDERATION

The research proposal was approved by the experts, prior to the pilot study and permission for the main study was obtained from the Director, Institute of Obstetrics and Gynecology, Chennai-8. Permission was obtained from ethical committee and also from the Chief of the Infertility clinic. The written consent of the participant was obtained before data collection; assurance, confidentiality and privacy were given to the study participants.

3.12 PILOT STUDY

Polite and Beck (2009) stated that a pilot study is a miniature of some parts of the actual study. A pilot study was conducted with 10 infertile men who visited infertility clinic of IOG, Chennai-8. The purpose was to find out the feasibility and practicability of the study design. The structured questionnaire were administered and found to be feasible. It took about 20-30minutes on an average for the participants to complete the questionnaire. Participants followed the structured questionnaire easily. On the whole, the structured questionnaire was found to be feasible and easy for the participants. The pilot study finding revealed that there is significant association between perceptions and acceptance of treatment by infertile men. Pilot study samples are not included in main study.

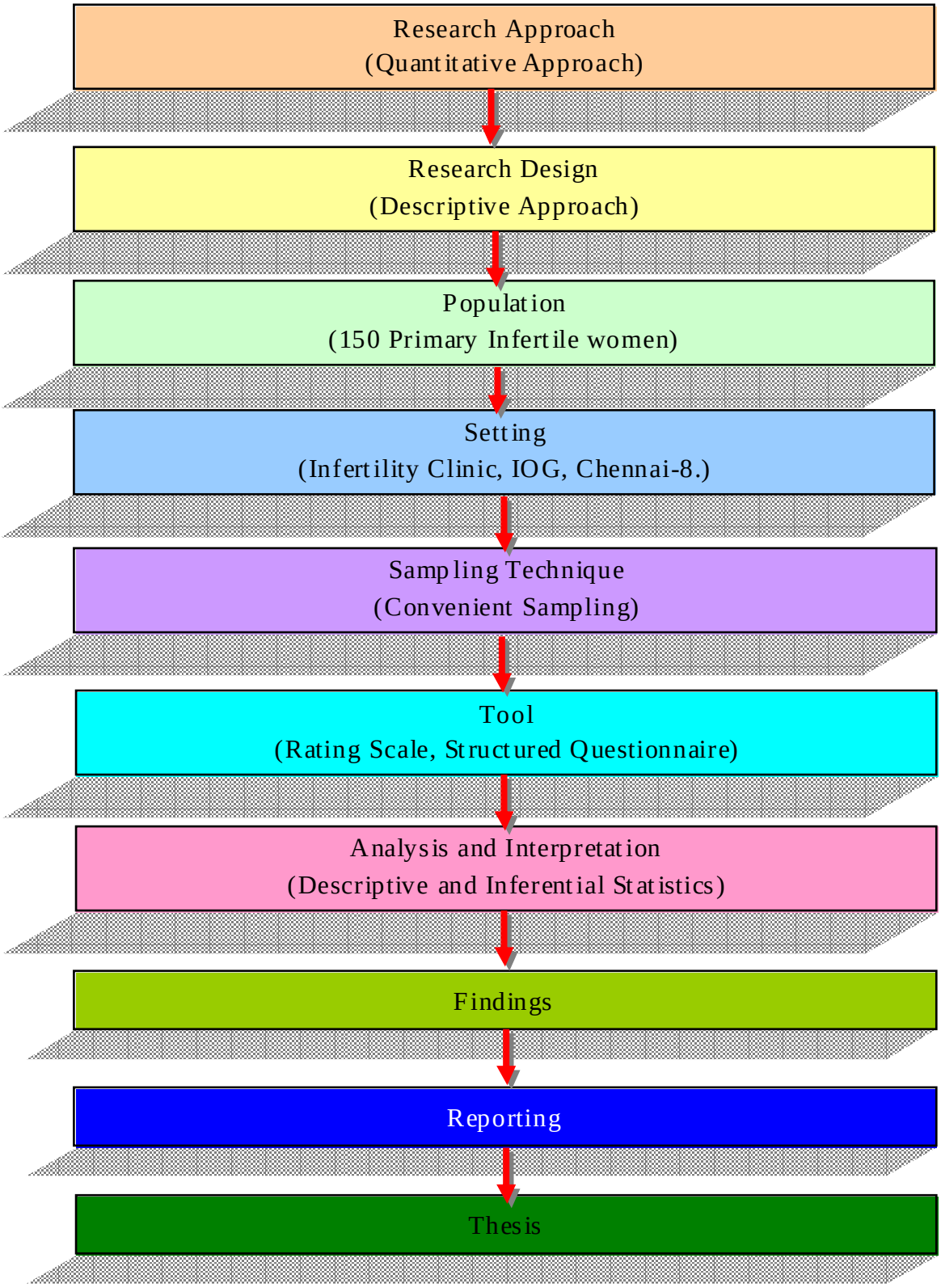
3.13 DATA COLLECTION

Data collection is the gathering of information needed to address a research problem. The study was conducted in the Infertility Clinic, IOG, and Chennai-8.The period of data collection was from 29.08.11 to 29.09.11. Prior to the data collection permission was obtained from the concerned authorities. The investigator administered questionnaire for assessing the perceptions and acceptance of treatment.

3.14 PLAN FOR DATA ANALYSIS

Collected data was analyzed by using descriptive and inferential statistics. Descriptive statistics includes mean and standard deviation. Inferential statistics include standard deviation Chi-square. The data was presented in the form of tables and figures.

FIGURE-2: SCHEMATIC REPRESENTATION OF RESEARCH METHODOLOGY



CHAPTER-IV
4.0. DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of the data collected. Analysis is a method for rendering quantitative, meaningful and providing intelligible information. So that research problem can be studied and tested including the relationship between the variables.

The data collected had been analyzed using appropriate statistical methods and the results are presented below:

ORGANIZATION OF THE DATA

Section I : Demographic variables of the data

Section II : Perceptions about male infertility

Section III : Acceptance of treatment by males

Section IV : Association between selected variables with perceptions

Section V : Association between selected variables with acceptance of treatment

SECTION-I

Table 2: Distribution of demographic variables of men with infertility

Demographic Variables		**frequency**	**%**
Age	20 -25 yrs	3	2.0%
	26 -30 yrs	44	29.3%
	31 -35 yrs	61	40.7%
	36 -40 yrs	42	28.0%
Education	No formal education	13	8.7%
	Primary	49	32.7%
	Secondary	54	36.0%
	Higher secondary	34	22.7%
Occupation	Unemployed	13	8.7%
	Employed	137	91.3%
Monthly Income	Rs.1000 -2000	19	12.7%
	Rs.2001 -3000	14	9.3%
	Rs.3001 -4000	35	23.3%
	>Rs.4000	82	54.7%
Type of family	Nuclear family	66	44.0%
	Joint family	84	56.0%
Age at marriage	20 -25 yrs	42	28.0%
	26 -30 yrs	79	52.7%
	31 -35 yrs	25	16.7%
	36 -40 yrs	4	2.7%

Demographic Variables		frequency	%
Period of Infertility	2 -4 yrs	71	47.3%
	5 -8 yrs	35	23.3%
	9 -12 yrs	21	14.0%
	>12 yrs	23	15.3%
Habits	Smoking	63	42.0%
	Alcohol	31	20.7%
	pan user	54	36.0%
	Drugs	2	1.3%
Use of contraceptives	Yes	16	10.7%
	No	134	89.3%
Years of Treatment	2 yrs	13	8.7%
	4 yrs	86	57.3%
	6 yrs	33	22.0%
	>6 yrs	18	12.0%

Table No. 2 shows that a higher proportion of men with infertility (41%) are within the age group of 31-35 years of age, more of them (36%) had a secondary education and majority of them (91%) were employed, 56% of them are living in joint family and 42% of them do have an habit of smoking and 57% of them are taking treatment for four years.

SECTION-II

Table 3: Distribution of men with infertility according to perceptions

Perceptions		*No*		*Rarely*		*Occasionally*		*Always*	
		n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Physiological	Do you have less appetite?	32	21.3%	95	63.3%	20	13.3%	3	2.0%
	Do you feel that you have reduced your weight?	27	18.0%	40	26.7%	75	50.0%	8	5.3%
	Do you suffer from body pain?	12	8.0%	47	31.3%	56	37.3%	35	23.3%
	Do you have tension headache?	19	12.7%	36	24.0%	57	38.0%	38	25.3%
	Do you feel easily fatigue?	18	12.0%	25	16.7%	55	36.7%	52	34.7%
	Do you suffer from any problem of ulcer?	63	42.0%	43	28.7%	39	26.0%	5	3.3%
	Do you have some sexual desire as before?	29	19.3%	49	32.7%	56	37.3%	16	10.7%
Psychological	Do you get angry very often?	26	17.3%	101	67.3%	22	14.7%	1	.7%
	Do you feel less interest in life?	21	14.0%	34	22.7%	86	57.3%	9	6.0%
	Do you have sleep disturbance?	16	10.7%	34	22.7%	58	38.7%	42	28.0%
	Do you have concentration?	21	14.0%	46	30.7%	71	47.3%	12	8.0%
	Do you feel guilty about not giving birth yet?	11	7.3%	41	27.3%	79	52.7%	19	12.7%

Perceptions		No		Rarely		Occasionally		Always	
		n	%	*n*	%	*n*	%	*n*	%
	Are you worried about your future?	11	7.3%	34	22.7%	82	54.7%	23	15.3%
	Do you have crying spells?	29	19.3%	40	26.7%	65	43.3%	16	10.7%
	Are you frustrated in your life?	18	12.0%	55	36.7%	68	45.3%	9	6.0%
	Do you feel worthless of yourself at any time?	31	20.7%	40	26.7%	68	45.3%	11	7.3%
	Do you feel lonely?	20	13.3%	47	31.3%	72	48.0%	11	7.3%
	Are you having problem in decision making?	14	9.3%	49	32.7%	69	46.0%	18	12.0%
	Do you feel it is curse from God?	17	11.3%	31	20.7%	63	42.0%	39	26.0%
	Do you lose your temper often?	14	9.3%	46	30.7%	73	48.7%	17	11.3%
	Are you satisfied in sex?	9	6.0%	34	22.7%	79	52.7%	28	18.7%
	Do you get psychological support from your partner?	11	7.3%	43	28.7%	70	46.7%	26	17.3%
Sociological	Do you join function as before?	30	20.0%	92	61.3%	23	15.3%	5	3.3%
	Do you face any problems with in laws?	34	22.7%	31	20.7%	76	50.7%	9	6.0%

Perceptions		No		Rarely		Occasionally		Always	
		n	%	n	%	n	%	n	%
	Do you quarrel or fight with your partner?	31	20.7%	55	36.7%	41	27.3%	23	15.3%
	Do you receive psychological support from your family?	15	10.0%	39	26.0%	62	41.3%	34	22.7%
	Does your partner extend support financially?	24	16.0%	46	30.7%	65	43.3%	15	10.0%
	Do you receive financial support from family member?	23	15.3%	49	32.7%	71	47.3%	7	4.7%
	Are you treated with respect?	9	6.0%	45	30.0%	78	52.0%	18	12.0%
	Are your relatives and neighbors visiting your house?	10	6.7%	42	28.0%	84	56.0%	14	9.3%
	Have you restricted your pleasure trips due to this problem?	11	7.3%	60	40.0%	71	47.3%	8	5.3%

The above table reveals that most of the infertile men are experiencing physiological perception (35%) and psychological perception (28%) and sociological perception (23%)

Table 4: Distribution of perceptions experienced by infertile men

	Perception	*Min-max score*	*Mean score*	*%*
Physiological	Do you have less appetite?	0-3	0.96	32.0%
	Do you feel that you have reduced your weight?	0-3	1.43	47.7%
	Do you suffer from body pain?	0-3	1.76	58.7%
	Do you have tension headache?	0-3	1.76	58.7%
	Do you feel easily fatigue?	0-3	1.94	64.7%
	Do you suffer from any problem of ulcer?	0-3	0.91	30.3%
	Do you have some sexual desire as before?	0-3	1.39	46.3%
Psychological	Do you get angry very often?	0-3	0.99	33.0%
	Do you feel less interest in life?	0-3	1.55	51.7%
	Do you have sleep disturbance?	0-3	1.84	61.3%
	Do you have concentration?	0-3	1.49	49.7%
	Do you feel guilty about not giving birth yet?	0-3	1.71	57.0%
	Are you worried about your future?	0-3	1.78	59.3%
	Do you have crying spells?	0-3	1.45	48.3%
	Are you frustrated in your life?	0-3	1.45	48.3%
	Do you feel worthless of yourself at any time?	0-3	1.39	46.3%
	Do you feel lonely?	0-3	1.49	49.7%
	Are you having problem in decision making?	0-3	1.61	53.7%
	Do you feel it is curse from God?	0-3	1.83	61.0%
	Do you lose your temper often?	0-3	1.62	54.0%
	Are you satisfied in sexual?	0-3	1.84	61.3%
	Do you get psychological support from your partner?	0-3	1.74	58.0%

Perception		*Min-max score*	*Mean score*	*%*
Sociological	Do you join function as before?	0-3	1.02	34.0%
	Do you face any problems with in laws?	0-3	1.40	46.7%
	Do you quarrel or fight with your partner?	0-3	1.37	45.7%
	Do you receive psychological support from your family?	0-3	1.77	59.0%
	Does your partner extend support financially?	0-3	1.47	49.0%
	Do you receive financial support from family members?	0-3	1.41	47.0%
	Are you treated with respect?	0-3	1.70	56.7%
	Are your relatives and neighbors visiting your house?	0-3	1.68	56.0%
	Have you restricted your pleasure trips due to this problem?	0-3	1.51	50.3%

The above table depicts that infertile males are having more perception in psychological perceptions (62%), some of them are experiencing some aspect of physiological perceptions (65%). Also among the men (59%) are experiencing sociological perceptions.

Table 5: Distribution of overall perception experienced by infertile men

Perception	*No. of questions*	*Min –Max score*	*Perception score*	
			Mean±SD	*%*
Physiological	7	0 – 21	10.15 ± 4.00	48.3%
Psychological	15	0 – 45	23.77±7.74	52.8%
Sociological	9	0 – 27	13.31±3.82	49.3%
OVERALL	31	0 -93	47.27±13.66	50.8%

Table 5 shows domain wise percentage of perception among infertile males.

They are having maximum perception in psychological factors (52.8%) and minimum perception in physiological factors (48.3%) and (49%) in sociological factors.

Table 6: Distribution of Infertile Men Experienced the Level of Perception

Level of perception	**frequency**	**%**
No perception	14	9.3%
Mild	45	30.0%
Moderate	82	54.7%
Severe	9	6.0%

Table no.6 shows the infertile males level of perception. 9.3% of the infertile males having no perception about infertility, 30% of them having mild perception, 54.7% of them having moderate perception and 6% of them having severe perception about infertility.

SECTION-III

Table 7: Distribution of infertile men with acceptance of treatment

Acceptance		*Never*		*Rarely*		*Sometimes*		*Most of the time*	
		n	***%***	***n***	***%***	***n***	***%***	***n***	***%***
Sequential	Have you been regular to the treatment?	3	2.0%	21	14.0%	70	46.7%	56	37.3%
	Did you exhaust with one option before considering another type of treatment?	21	14.0%	63	42.0%	59	39.3%	7	4.7%
	Did you exhaust with one option before completing the treatment?	32	21.3%	67	44.7%	41	27.3%	10	6.7%
	Do you feel that duration of the treatment made you to exhaust with one treatment before considering other treatment?	17	11.3%	67	44.7%	56	37.3%	10	6.7%
	Do you feel that failure of the treatment made you to exhaust with one treatment before considering another kind of treatment?	17	11.3%	81	54.0%	45	30.0%	7	4.7%
Back tracking	Did you retry the treatment with a new physician?	19	12.7%	74	49.3%	45	30.0%	12	8.0%
	Did you retry the treatment with the same physician?	11	7.3%	76	50.7%	45	30.0%	18	12.0%
	Have you feel retrying the treatment with new physician who gives satisfaction for the infertility treatment?	10	6.7%	68	45.3%	57	38.0%	15	10.0%

Acceptance		Never		Rarely		Sometimes		Most of the time	
		n	%	*n*	%	*n*	%	*n*	%
	Have you been encouraged by your family members to retry the treatment with new physician?	9	6.0%	72	48.0%	50	33.3%	19	12.7%
	Have you been encouraged by your spouse to retry the treatment with same physician?	12	8.0%	78	52.0%	47	31.3%	13	8.7%
Taking a break	Did you take break for awhile and then continue with the treatment?	19	12.7%	75	50.0%	37	24.7%	19	12.7%
	Did you withdraw from the treatment before completion with other treatment?	19	12.7%	66	44.0%	56	37.3%	9	6.0%
	Did you break with one treatment option then continue with same treatment?	16	10.7%	76	50.7%	45	30.0%	13	8.7%
	Did you take break with one treatment option and then continue with same treatment?	7	4.7%	34	22.7%	60	40.0%	49	32.7%
	Did you have the idea of adopting the baby?	19	12.7%	59	39.3%	61	40.7%	11	7.3%
Getting stuck	Did the failure of the treatment made you to withdraw from the treatment?	15	10.0%	76	50.7%	53	35.3%	6	4.0%
	Did the cost of the treatment made you to withdraw from the treatment?	16	10.7%	59	39.3%	64	42.7%	11	7.3%

Acceptance		Never		Rarely		Sometimes		Most of the time	
		n	%	*n*	%	*n*	%	*n*	%
	Did the investigations of the treatment made you to stick with the treatment?	27	18.0%	57	38.0%	57	38.0%	9	6.0%
	Have you felt the duration of infertility made you to withdraw from the treatment?	16	10.7%	71	47.3%	54	36.0%	9	6.0%
	Do you feel that causes of the fertility made you to withdraw from the treatment?	13	8.7%	74	49.3%	57	38.0%	6	4.0%
Paralleling	Do you try with multiple treatment options simultaneously?	18	12.0%	72	48.0%	47	31.3%	13	8.7%
	Do you try with other treatment regimen such as siddha or ayurvedha?	19	12.7%	68	45.3%	53	35.3%	10	6.7%
	Have you thought of taking multiple options to help you to conceive?	14	9.3%	71	47.3%	59	39.3%	6	4.0%
	Do you try one treatment option simultaneously with any other methods of treatment?	17	11.3%	70	46.7%	57	38.0%	6	4.0%
	Do you try with treatment simultaneously with any other physician?	16	10.7%	65	43.3%	62	41.3%	7	4.7%

The above table shows that majority (47%) of the infertile males is not regular to the treatment, some (33%) are taking a break and some are paralleling (7%).

Table 8: Distribution of infertile men with overall acceptance of treatment

Items		*Min – Max score*	*Mean score*	*%*
Sequential	Have you been regular to the treatment?	0-3	2.19	73.0%
	Did you exhaust with one option before considering another type of treatment?	0-3	1.35	45.0%
	Did you exhaust with one option before completing the treatment?	0-3	1.19	39.7%
	Do you feel that duration of the treatment made you to exhaust with one treatment before considering other treatment?	0-3	1.39	46.3%
	Do you feel that failure of the treatment made you to exhaust with one treatment before considering another kind of treatment?	0-3	1.28	42.7%
Back tracking	Did you retry the treatment with new physician?	0-3	1.33	44.3%
	Did you retry the treatment with same physician?	0-3	1.47	49.0%
	Have you feel retrying the treatment with new physician gives satisfaction for the infertility treatment?	0-3	1.51	50.3%
	Have you been encouraged by your family members to retry the treatment with new physician?	0-3	1.53	51.0%
	Have you been encouraged by your spouse to retry the treatment with same physician?	0-3	1.41	47.0%
Taking a break	Did you take break for awhile and then continue with the treatment?	0-3	1.37	45.7%
	Did you withdraw from the treatment before completion with other treatment?	0-3	1.37	45.7%
	Did you break with one treatment option then continue with same treatment?	0-3	1.37	45.7%
	Did you take break with one treatment option and then continue with same treatment?	0-3	2.01	67.0%
	Did you have the idea of adopting the baby?	0-3	1.43	47.7%

Items		Min – Max score	Mean score	%
Getting stuck	Did the failure of the treatment made you to withdraw from the treatment?	0-3	1.33	44.3%
	Did the cost of the treatment made you to withdraw from the treatment?	0-3	1.47	49.0%
	Did the investigations of the treatment made you to stick with the treatment?	0-3	1.32	44.0%
	Have you felt the duration of infertility made you to withdraw from the treatment?	0-3	1.37	45.7%
	Do you feel that causes of the fertility made you to withdraw from the treatment?	0-3	1.37	45.7%
Paralleling	Do you try with multiple treatment options simultaneously?	0-3	1.37	45.7%
	Do you try with other treatment regimen such as siddha or ayurvedha?	0-3	1.36	45.3%
	Have you thought taking multiple options help you to conceive?	0-3	1.38	46.0%
	Do you try one treatment option simultaneously with any other methods of treatment?	0-3	1.35	45.0%
	Do you try with treatment simultaneously with any other physician?	0-3	1.40	46.7%

The above table interprets that infertile males have more acceptance in this aspects sequential (73%), back tracking (51%), taking a break (67%), getting stuck (49%) and paralleling (47%).

Table 9: Distribution of infertile men with percentage of acceptance of treatment

Acceptance	No. of questions	Min –Max score	Acceptance score	
			Mean±SD	%
Sequential tracking	5	0 – 15	7.41 ±2.52	49.4%
Back tracking	5	0 – 15	7.24±2.47	48.3%
Taking a break	5	0 – 15	7.54±2.92	50.3%
Getting stuck	5	0 – 15	6.87±2.62	45.8%
Paralleling	5	0 – 15	6.85±2.79	45.7%
OVERALL	25	0 -75	35.91±10.74	47.9%

Table 9 shows each domain wise percentage of acceptances among infertile males. They have maximum acceptance in taking a break (50.3%) and minimum score in paralleling (45.7%)

Table 10: Distribution of infertile men with level of acceptance of treatment

Level of acceptance	Frequency	%
Regular	10	6.7%
Less irregular	69	46.0%
Moderate irregular	65	43.3%
Highly irregular	6	4.0%

Table no.9 shows the infertile males level of acceptance. 6.7% of the infertile males are regular, 46% of them are less irregular, 43.3% of them are moderate irregular and 4% of them are highly irregular.

Table 11: Correlation between perception score and acceptance score

	Mean±SD	Karl pearson correlation coefficient	Interpretation
Perception score Acceptance score	47.27±13.66 35.91±10.74	R=0.43 P=0.01**	There is a moderate positive relationship between perception score and acceptance score

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

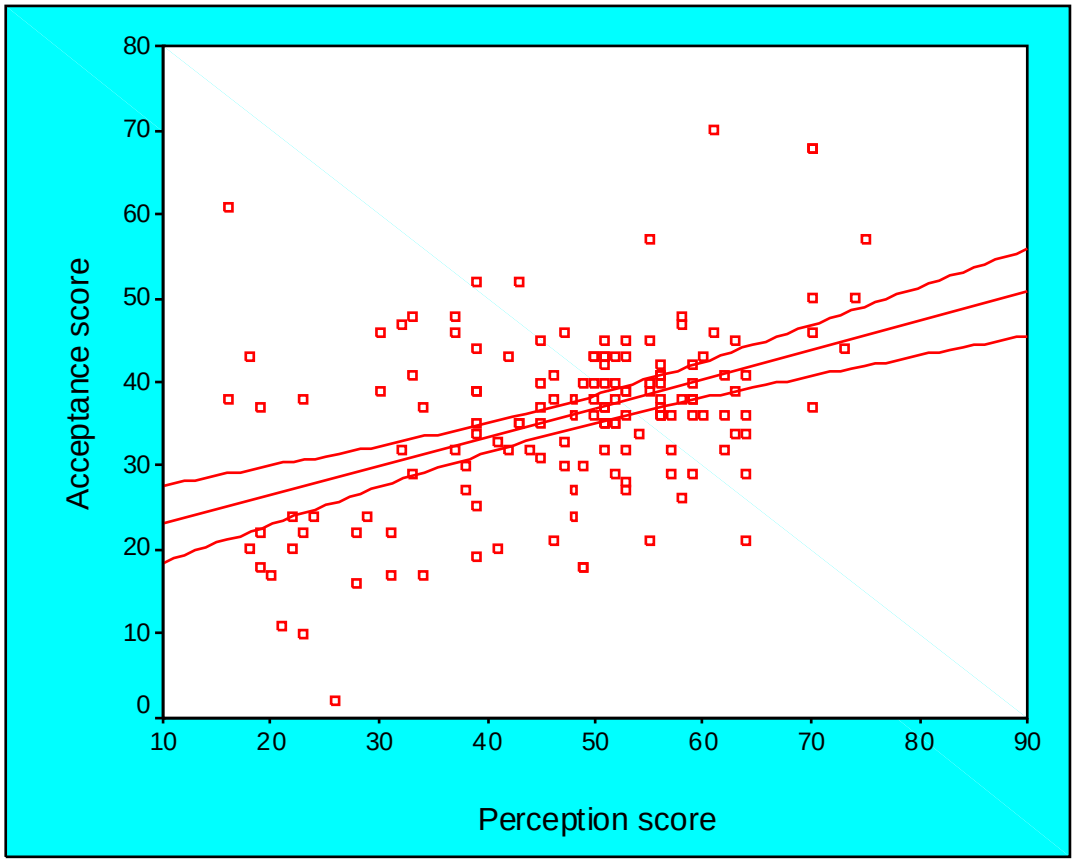


Fig 3: Scatter plot shows the positive correlation between perception score and acceptance score(r=0.43)

SECTION-IV

Table 12: Association between level of perception and demographic variables

		Level of perception								Total	Pearson chi square
		No perception		Mild		Moderate		Severe			
		n	%	n	%	n	%	n	%		
Age	20 -25 yrs	1	33.3%	1	33.3%	1	33.3%	0	0.0%	3	χ^2=5.16 P=0.82 DF=9
	26 -30 yrs	4	9.1%	15	34.1%	24	54.5%	1	2.3%	44	
	31 -35 yrs	5	8.2%	19	31.1%	33	54.1%	4	6.6%	61	
	36 -40 yrs	4	9.5%	10	23.8%	24	57.1%	4	9.5%	42	
Education	No formal education	5	38.4%	2	15.4%	5	38.4%	1	7.8%	13	χ^2=19.90 P=0.02* DF=9
	Primary	5	10.2%	14	28.6%	26	53.1%	4	8.1%	49	
	Secondary	2	3.7%	17	31.4%	32	59.3%	3	5.6%	54	
	Higher secondary	2	5.9%	12	35.3%	19	55.9%	1	2.9%	34	
Occupation	Unemployed	1	7.7%	5	38.5%	7	53.8%	0	0.0%	13	χ^2=1.23 P=0.74 DF=3
	Employed	13	9.5%	40	29.2%	75	54.7%	9	6.6%	137	
Monthly Income	Rs.1000 - 2000	1	5.3%	4	21.1%	10	52.6%	4	21.1%	19	χ^2=10.28 P=0.33 DF=9
	Rs.2001 - 3000	1	7.1%	5	35.7%	8	57.1%	0	0.0%	14	
	Rs.3001 - 4000	3	8.6%	10	28.6%	20	57.1%	2	5.7%	35	
	>Rs.4000	9	11.0%	26	31.7%	44	53.7%	3	3.7%	82	
Type of family	Nuclear family	9	13.6%	17	25.8%	38	57.6%	2	3.0%	66	χ^2=4.96 P=0.18 DF=3
	Joint family	5	6.0%	28	33.3%	44	52.4%	7	8.3%	84	
Age at marriage	20 -25 yrs	4	9.5%	11	26.2%	24	57.1%	3	7.1%	42	χ^2=222 P=0.22 DF=9
	26 -30 yrs	6	7.6%	27	34.2%	42	53.2%	4	5.1%	79	
	31 -35 yrs	3	12.0%	6	24.0%	14	56.0%	2	8.0%	25	
	36 -40 yrs	1	25.0%	1	25.0%	2	50.0%	0	0.0%	4	

		Level of perception								Total	Pearson chi square
		No perception		Mild		Moderate		Severe			
		n	%	n	%	n	%	n	%		
Period of Infertility	2 -4 yrs	10	14.1%	26	36.6%	34	47.9%	1	1.4%	71	χ^2=29.04 P=0.001*** DF=9
	5 -8 yrs	2	5.7%	8	22.8%	24	68.6%	1	2.9%	35	
	9 -12 yrs	1	4.8%	5	23.8%	13	61.9%	2	9.5%	21	
	>12 yrs	1	4.3%	6	26.1%	11	47.8%	5	21.7%	23	
Habits	Smoking	3	4.8%	14	22.2%	39	61.9%	7	11.1%	63	χ^2=13.28 P=0.15 DF=9
	Alcohol	3	9.7%	12	38.7%	15	48.4%	1	3.2%	31	
	Pan user	0	0.0%	0	0.0%	2	100.0%	0	0.0%	2	
	Drugs	8	14.8%	19	35.2%	26	48.1%	1	1.9%	54	
Use of contraceptives	Yes	3	18.8%	7	43.8%	5	31.3%	1	6.3%	16	χ^2=4.63 P=0.20 DF=9
	No	11	8.2%	38	28.4%	77	57.5%	8	6.0%	134	
Years of Treatment	2 yrs	4	30.7%	6	46.2%	3	23.1%	0	0.0%	13	χ^2=22.48 P=0.01* DF=9
	4 yrs	4	4.6%	24	27.9%	53	61.6%	5	5.8%	86	
	6 yrs	4	12.1%	11	33.3%	16	51.5%	2	6.1%	33	
	>6 yrs	2	11.1%	4	22.2%	10	55.5%	2	11.1%	18	

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

Table no 12 shows that association between infertile males' level of perception and their demographic variables .More educated, who completed secondary level (49) and higher secondary (54), more infertile period that is 5-8yrs and more years of treatment (4years) are significantly associated with level of perception. Association between demographic and variables level of perception was analyzed by using Pearson chi-square test.

SECTION-V

Table 13: Association between level of acceptance and demographic variables

		Level of acceptance								*Total*	*Pearson chi square*
		Regular		*Less irregular*		*Moderate irregular*		*Highly irregular*			
		n	*%*	*n*	*%*	*n*	*%*	*n*	*%*		
Age	20 -25 yrs	0	0.0%	2	66.7%	1	33.3%	0	0.0%	3	χ^2=10.67 P=0.29 DF=9
	26 -30 yrs	3	6.8%	15	34.1%	25	56.8%	1	2.3%	44	
	31 -35 yrs	3	4.9%	32	52.5%	25	41.0%	1	1.6%	61	
	36 -40 yrs	4	9.5%	20	47.6%	14	33.3%	4	9.5%	42	
Education	No formal education	0	0.0%	5	38.5%	7	53.8%	1	7.7%	13	χ^2=9.46 P=0.39 DF=9
	Primary	3	6.1%	23	46.9%	22	44.9%	1	2.0%	49	
	Secondary	2	3.7%	26	48.1%	22	40.7%	4	7.4%	54	
	Higher secondary	5	14.7%	15	44.1%	14	41.2%	0	0.0%	34	
Occupation	Unemployed	0	0.0%	7	53.8%	6	46.2%	0	0.0%	13	χ^2=1.73 P=0.63 DF=3
	Employed	10	7.3%	62	45.3%	59	43.1%	6	4.4%	137	
Monthly Income	Rs.1000 - 2000	0	0.0%	6	31.6%	10	52.6%	3	15.8%	19	χ^2=18.67 P=0.03* DF=9
	Rs.2001 - 3000	0	0.0%	7	50.0%	7	50.0%	0	0.0%	14	
	Rs.3001 - 4000	0	0.0%	20	57.1%	14	40.0%	1	2.9%	35	
	>Rs.4000	10	12.2%	36	43.9%	34	41.5%	2	2.4%	82	
Type of family	Nuclear family	4	6.1%	32	48.5%	27	40.9%	3	4.5%	66	χ^2=0.47 P=0.97 DF=3
	Joint family	6	7.1%	37	44.0%	38	45.2%	3	3.6%	84	
Age at marriage	20 -25 yrs	2	4.8%	16	38.1%	21	50.0%	3	7.1%	42	χ^2=35.06 P=0.001*** DF=9
	26 -30 yrs	3	3.8%	39	49.4%	34	43.0%	3	3.8%	79	
	31 -35 yrs	2	8.0%	13	52.0%	10	40.0%	0	0.0%	25	
	36 -40 yrs	3	75.0%	1	25.0%	0	0.0%	0	0.0%	4	

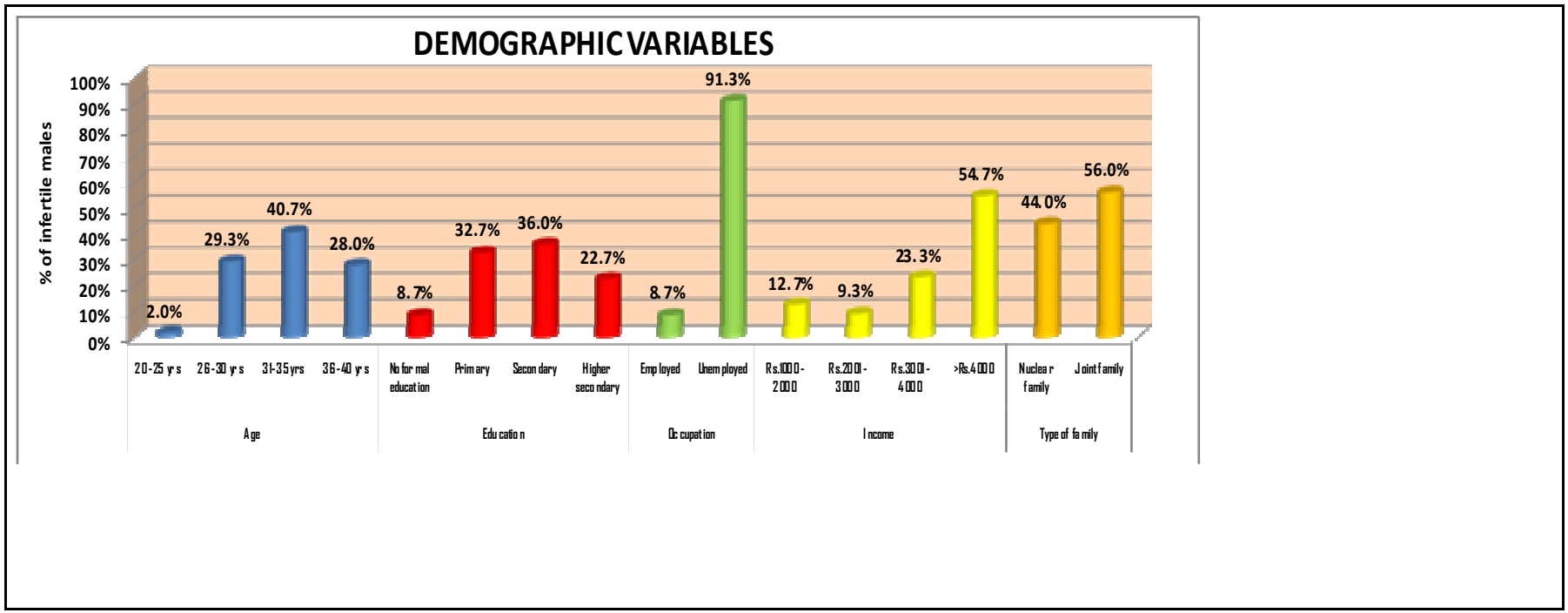
		Level of acceptance								Total	Pearson chi square
		Regular		Less irregular		Moderate irregular		Highly irregular			
		n	%	n	%	n	%	n	%		
Period of Infertility	2 -4 yrs	10	14.1%	32	45.1%	28	39.4%	1	1.4%	71	χ^2=34.52 P=0.001*** DF=9
	5 -8 yrs	0	0.0%	19	54.3%	16	45.7%	0	0.0%	35	
	9 -12 yrs	0	0.0%	10	47.6%	11	52.4%	0	0.0%	21	
	>12 yrs	0	0.0%	8	34.8%	10	43.5%	5	21.7%	23	
Habits	Smoking	4	6.3%	29	46.0%	26	41.3%	4	6.3%	63	χ^2=7.81 P=0.55 DF=9
	Alcohol	1	3.2%	11	35.5%	19	61.3%	0	0.0%	31	
	Pan user	0	0.0%	1	50.0%	1	50.0%	0	0.0%	2	
	Drugs	5	9.3%	28	51.9%	19	35.2%	2	3.7%	54	
Use of contraceptives	Yes	2	12.5%	4	25.0%	9	56.2%	1	6.3%	16	χ^2=3.54 P=0.31 DF=9
	No	8	5.2%	65	49.3%	56	41.8%	5	3.7%	134	
Years of Treatment	2 yrs	0	0.0%	9	69.2%	4	30.8%	0	0.0%	13	χ^2=8.39 P=0.50 DF=9
	4 yrs	6	7.0%	36	41.9%	40	46.5%	4	4.7%	86	
	6 yrs	2	6.1%	19	57.6%	11	33.3%	1	3.0%	33	
	>6 yrs	2	11.1%	5	27.8%	10	55.6%	1	5.6%	18	

* Significant at P≤0.05 ** highly significant at P≤0.01 *** very high significant at P≤0.001

Table no 13 shows the association between infertile males' level of acceptance and their demographic variables.

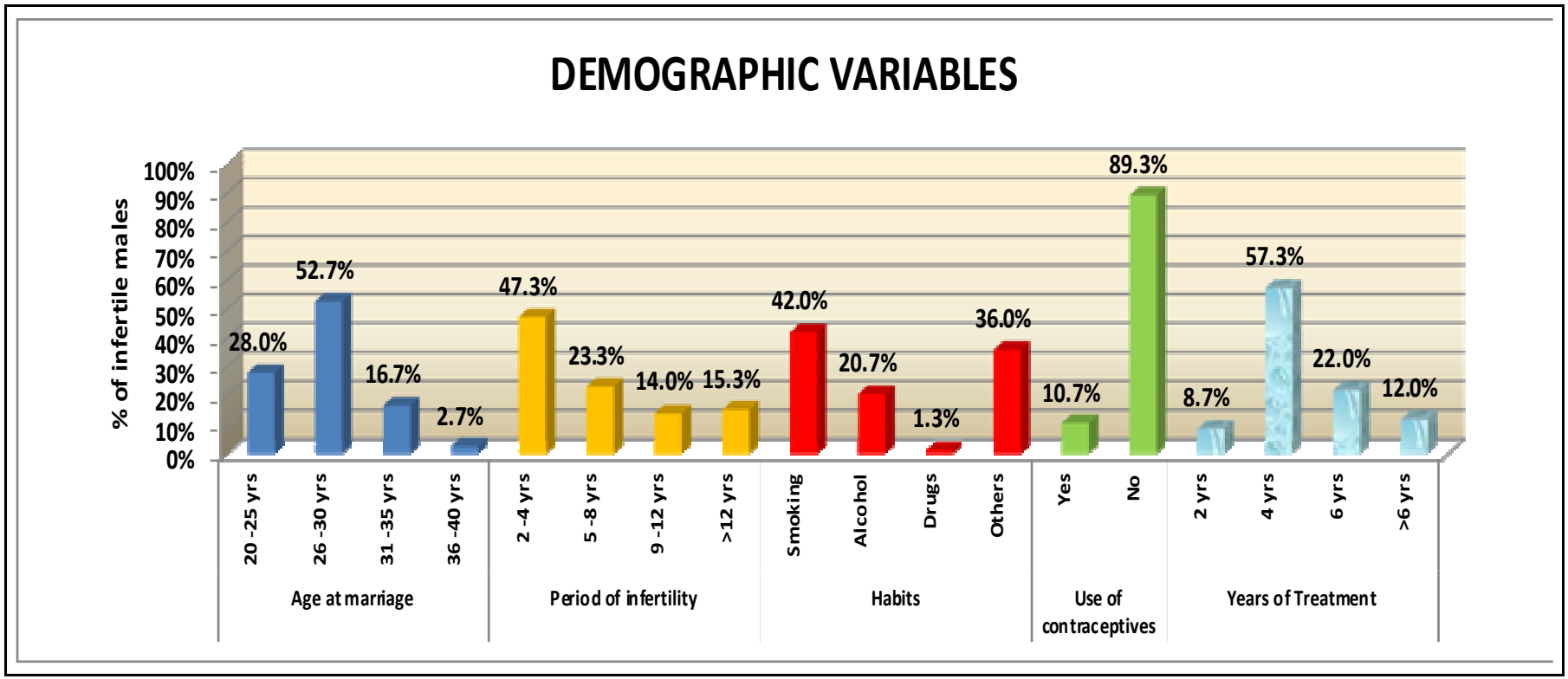
More income (>4000), more infertile period (2-4years) and late marriages (31-35years) are significantly associated with level of acceptance. Association between demographic variables and level of acceptance was analyzed by using Pearson chi-square test.

Figure-:4 Distribution of demographic variable of infertile men.



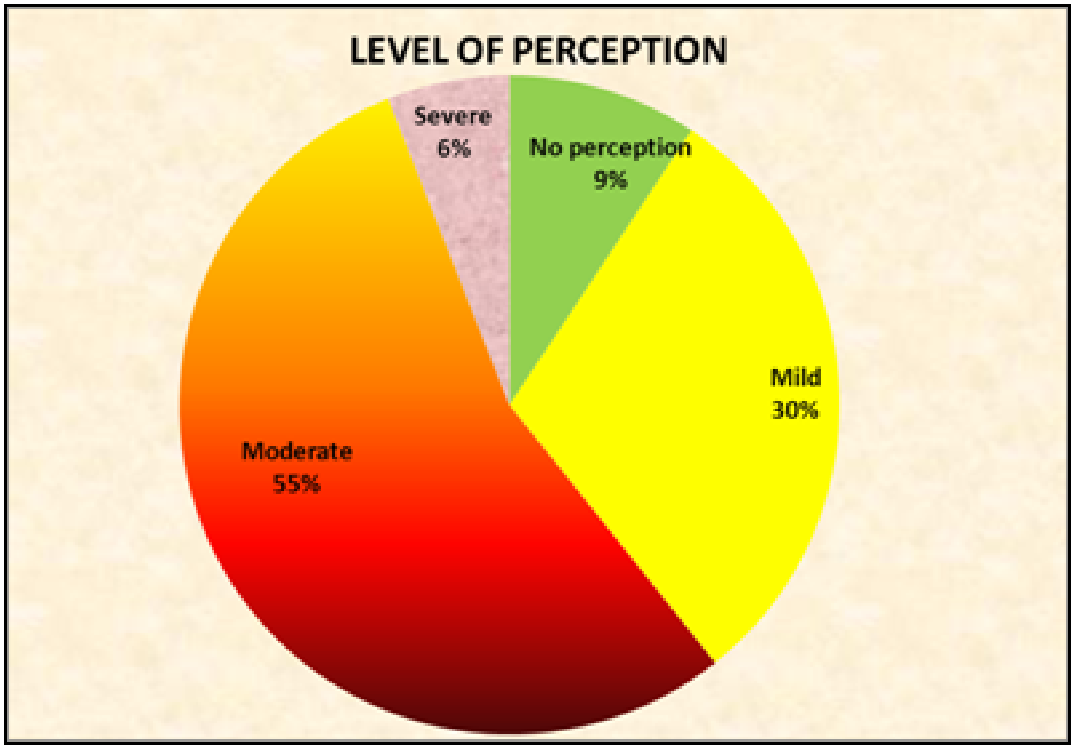
The above diagram depicts that among 150 subjects 40.7% were at the age group of 31-35yrs, 36% of them completed secondary education, 91.3% of them are employed, 54.7% of them earning more than Rs.4000 per month and 56% of them living in joint family.

Figure-: 5 Distribution of demographic variable of infertile men



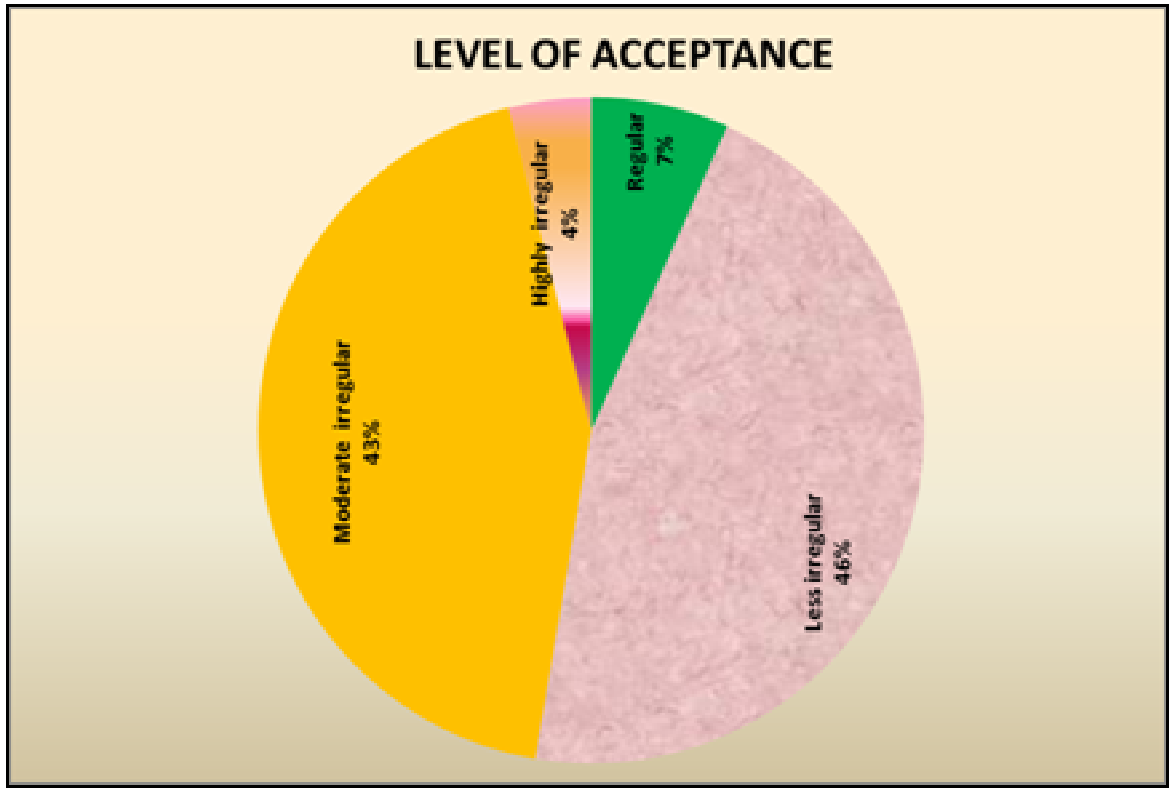
The above picture reveals that 52.7% of men were got married at the age of 26-30years, majority (47.3%) of their infertility period is 2-4years, 42% of them are having the habit of smoking, 89.3% are not using any type of contraceptives and 57.3% of them are taking treatment for 4years.

Figure -:6 Distribution of men with infertility according to the perceptions



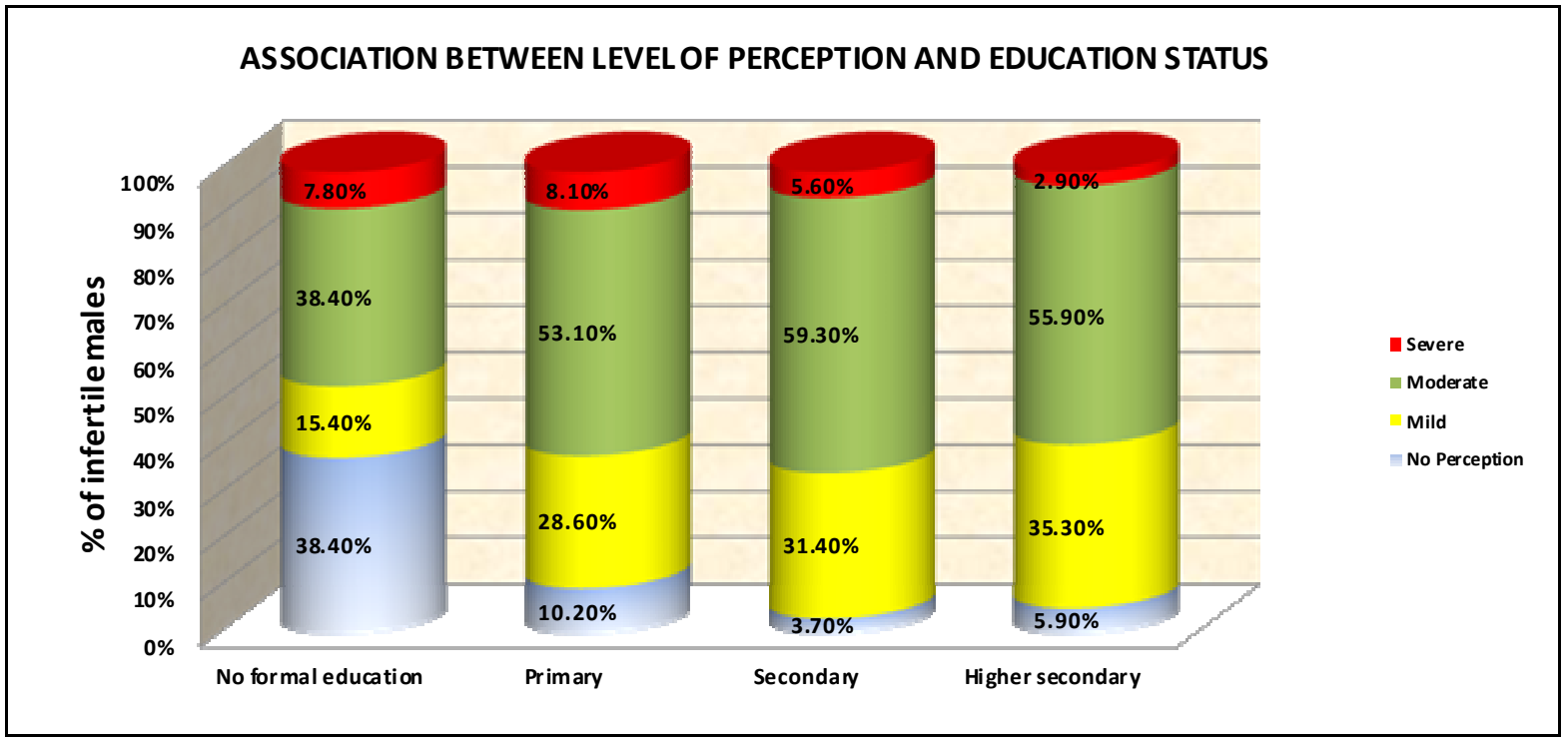
The above figure reveals that majority of the infertile men (55%) have moderate perception, and some (30%) have mild perception and only 6% of them have severe perception. Among this only 9% do not experience perception about infertility.

Figure -:7 Distribution of level of acceptance of treatment by infertile men



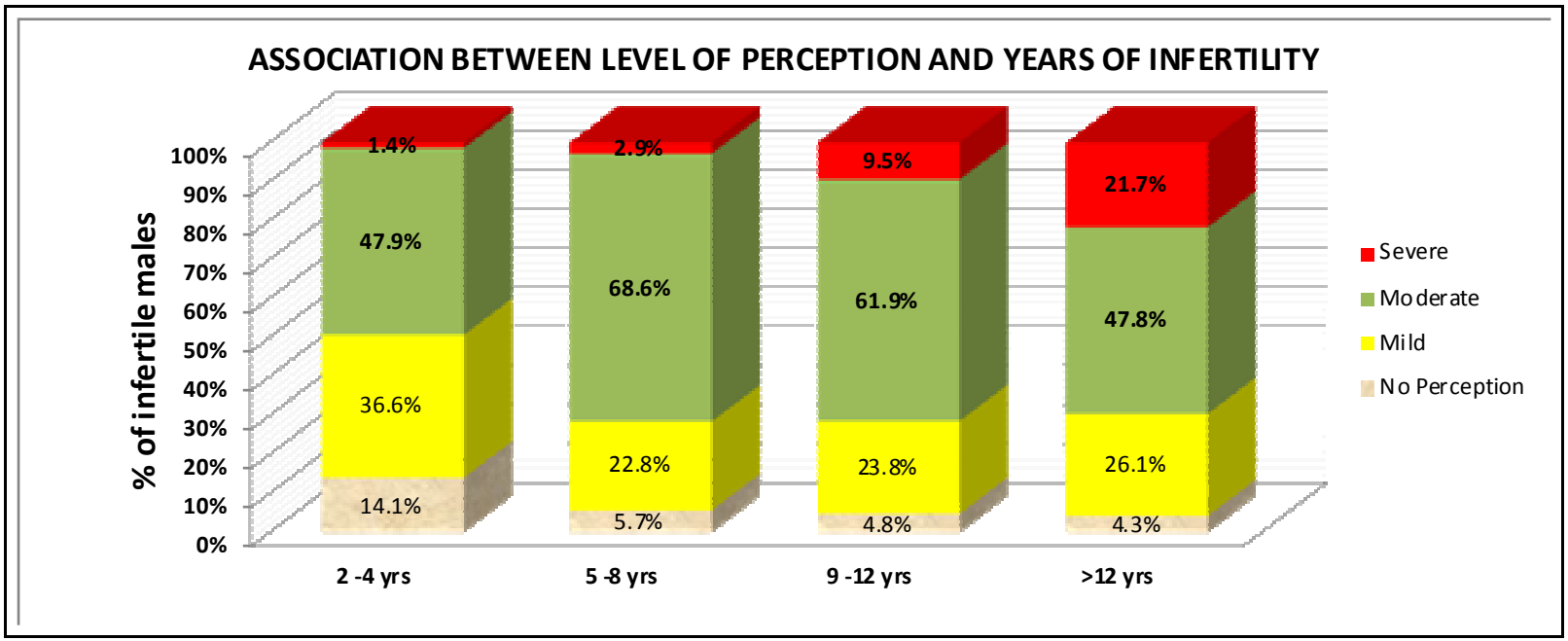
The above diagram shows that the infertile males level of acceptance. 6.7% of the infertile males are regular, 46% of them are less irregular, 43.3% of them are moderate irregular and 4% of them are highly irregular.

Figure: 8: Association between level of perception and educational status



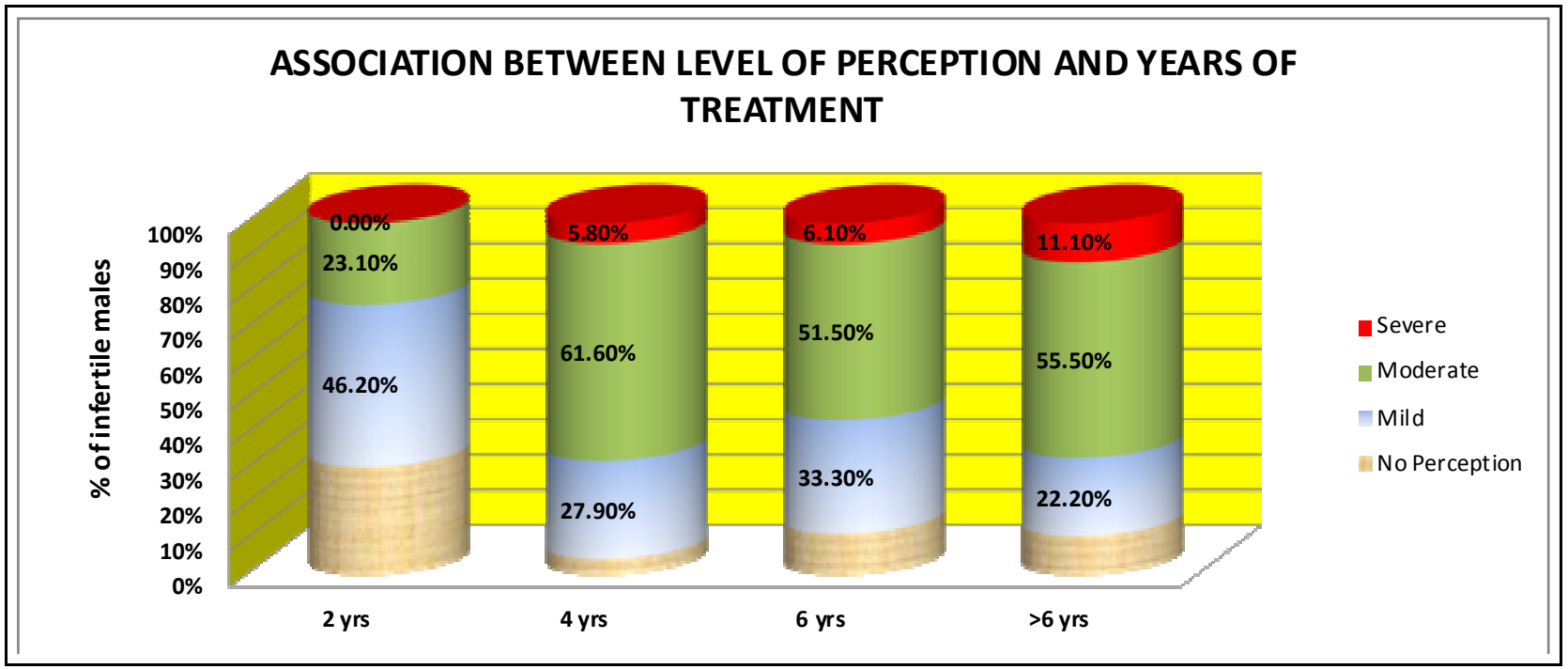
The above diagram interprets that there is a significant association between education and level of perception. Majority of the men (59%) have got secondary education and experience moderate level of perception.

Figure-:9 Association between level of perception and years of treatment



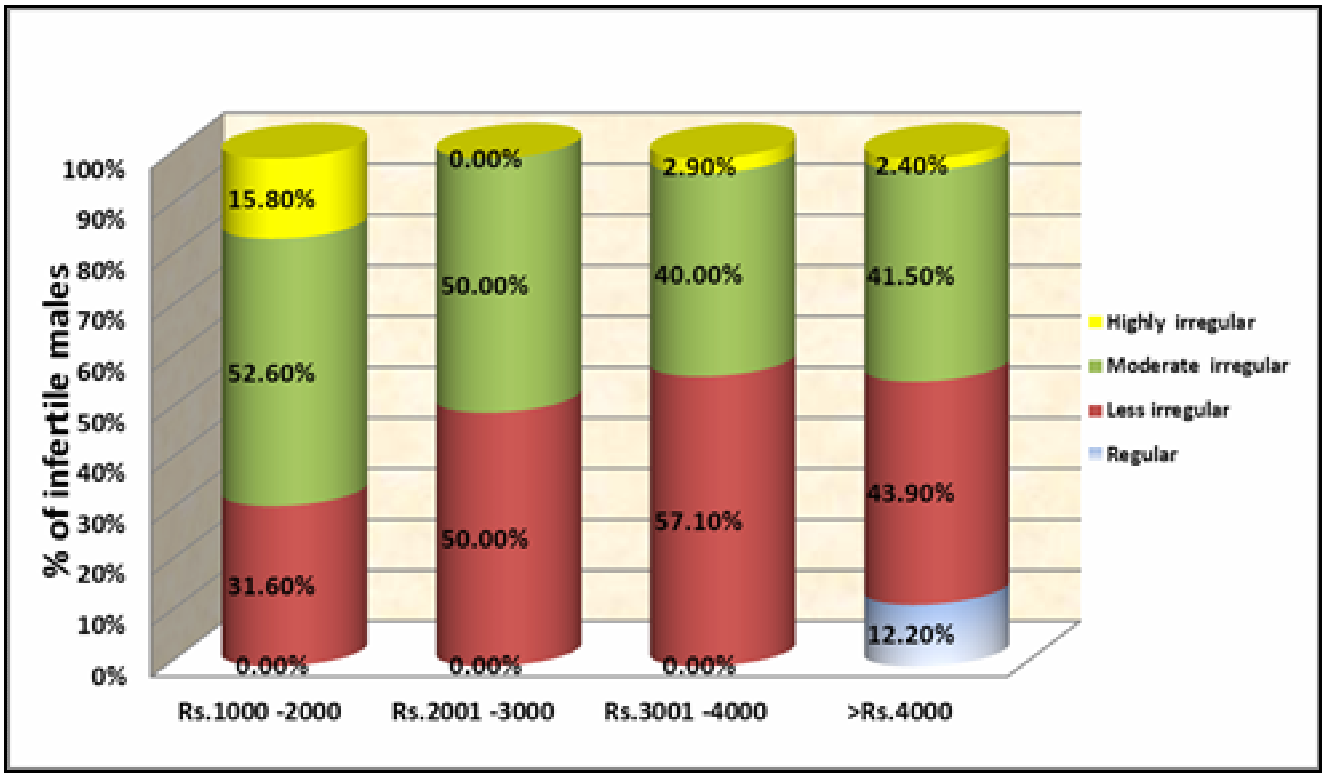
The above diagram interprets that there is a highly significant association between level of perception and period of infertility. Majority of the men (67%) have a moderate perception in period of 5-8yrs after diagnosing infertility. Men with more years of infertility are at risk for having severe perception.

Figure-:10 Association between level of perception and years of treatment



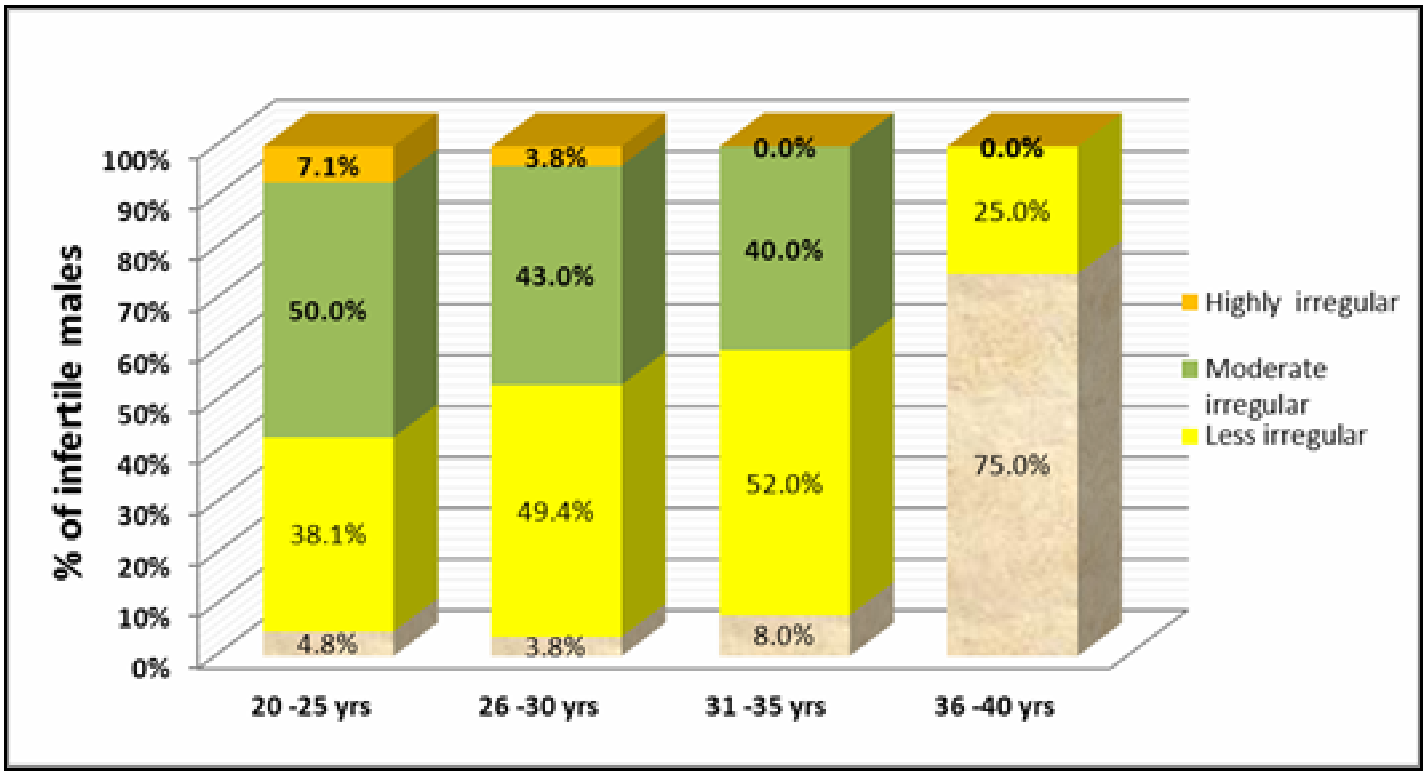
The above diagram interprets that there is significant association between years of treatment and level of perception. Majority of the men (61%) have moderate level of perception with 4 years of treatment. Infertile men who are taking more years of treatment for many years are prone to develop increasing level of perception.

Figure-:11 Association between acceptance of treatment and monthly income



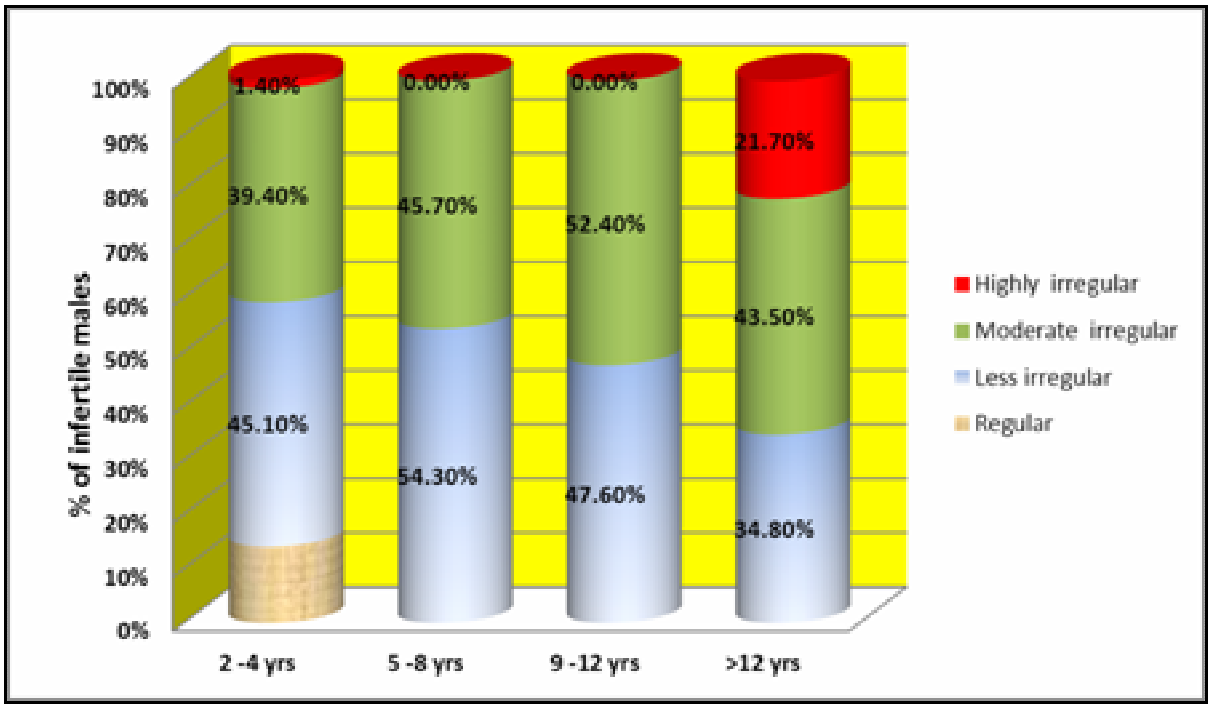
The above diagram interprets that there is a significant association between monthly income and acceptance of treatment by infertile men. Majority of the men (57%) who earns Rs 3001-4000 are moderately irregular in taking treatment which lead to being highly irregular if they are not regular for treatment.

Figure-12: Association between acceptance of treatment and age at marriage



The above diagram reveals that there is a highly significant association between acceptance of treatment by male and their age at marriage. Majority of the men (50%) are moderately irregular when they got married at the age of 20-25years. If the age advances they are less irregular in their nature.

Figure-13: Association between acceptance of treatment and period of infertility



The above diagram depicts that there is a highly significant association between acceptance of treatment and period of infertility. Majority of the men (52%) in period of infertility between 9-12years having moderate irregularity in taking treatment. If the period becomes advances they become highly irregular due to stress and the long period of taking treatment for their infertility.

CHAPTER – V
5.0. DISCUSSION

Infertility is considered as a "couple problem," because of which partner is found to be responsible for the reproductive failure, both partners are implicated, and both must contribute to its remedy. Nevertheless, it is believed that at least 50% of infertility is caused by male factors, such as deficiencies in sperm production and blockages in the sperm delivery system. Specifically, statistics show that 33% of problems can be traced directly to male origins, 33% to pure female-factor infertility and 33% are combination of male- and female-factor infertility. However, historically more attention has been focused on treating female infertility than male factor problems. One reason for this is the number of specialists that practice reproductive medicine. The American Society of Reproductive Medicine (ASRM) reported that in 2007, 65% of its membership was made up of obstetricians and gynecologists, whereas less than 10% were urologists or andrologists. Typically, male infertility treatment has been circumvented rather than treated directly.

In general, a man's reaction to infertility has been viewed as taking less of an emotional toll than his partner's. His reaction to his own infertility is often construed as interdependent with his partner's. Thus if she is coping well, he will follow accordingly. However, if she is having a difficult time, then his emotional stability will be compromised. He is often primarily delegated to the role of hand-holder, in charge of providing support for his partner during her grieving process. Little room is left for dealing with his own feelings of loss and sadness. This conforms to society's gender expectations, in which men are not given permission to express deep feelings of loss; on the contrary, they are encouraged to suppress emotions. Thus, society and the medical profession combined, inadvertently conspire to ignore or underestimate the man's responsibility and role in the infertility process.

Although there is a paucity of psychological studies that examine male infertility, they do concur that a significant proportion of infertile men do experience a myriad of psychological wounds. These can include

guilt, shame, anger, and isolation, a sense of personal failure, lowering of self-esteem, feelings of inadequacy, change in self- and sexual self- image, and a loss of sexual appetite. Male also report feeling specific losses when infertile, such as loss of genetic continuity and passing on the family name, loss of male sexual identity, loss of their ability to control their own lives, and loss of their ability to provide for their partners. Then of course there is the anticipatory and performance anxiety that is more often than not present, when men must produce a semen sample for analysis or treatment. One study found that 80% of 100 infertile men reported guilty feelings, both about their perceived inability to prove their manhood and to fulfill their partners' desires to have children ***(Schover et al,1992).*** Consequently, infertile men can suffer from episodes of depression, anxiety, sleep disturbances and sexual difficulties. Furthermore, their feelings of inadequacy have been shown to lead to detachment in the marriage, with breakdowns in communication and commitment. Secondary psychological disorders, such as substance abuse and sexual dysfunction, are not uncommon occurrences.

This study was an attempt to identify perceptions and acceptance of treatment by male infertility. As the investigator had evidenced many psychological, physiological and social problems experienced by these men with infertility, it was planned to take up such a study. Some of the most common perceptions were identified through this study, which have been analyzed and interpreted. This chapter deals with a detailed discussion on the study findings interpreted from the statistical analysis. The findings are discussed in relation to the objectives of the study.

The socio demographic characteristics of the clients attending infertility clinic are depicted in table 2. It was observed that higher proportion of men with infertility (41%) were within the age group of 31-35 years of age, more of them (36%) had completed their secondary education and majority(91%) of them were employed as electricians, drivers and work exposure is related to hot environment and chemicals which may be their preceding cause for their infertility. Majority (56%) of them was in a joint family and more than half were (52%) married at the age of 26-30years.

Regarding habits, smoking (42%) was the highest among them and there is no (89%) use of contraceptives among men with infertility. Majority of (47%) men were 2-4years after diagnosed period of infertility and 57% taking treatment for 4years. The socio demographic data of the respondents reveal that infertility is more prevalent among the middle aged men. Men who are employed are those who come out with their problems to such infertility clinics. Even then they are not voluntarily coming for the investigations and treatment because there is lack of specialty alone for men in Government setups and even in private also. Also their working conditions are an emotional support for them and yet they perceive lot of psychological and sociological perceptions about their infertility and they could not able to come for regular treatment.

(i) The first objective of the study was to assess the perceptions experienced by infertile men

The men with the perceptions were interpreted in table 2 & 3. Infertile males are having more perception in these aspects. The physiological perceptions which they experiences more are body pain (23%), tension headache (25%) and feels easily fatigue (35%). The psychological perceptions is the most high proportion when compare to other perceptions that are sleep disturbance (28%), curse from God (26%). The sociological perceptions are quarrel or fight with your partner (15%), and psychological support from your family (28%). Infertile males are having more perception in these aspects.

Jane Bainbridge and Laura Peron ace 2010 published the study of "male infertility and emotional wellbeing". This study focused on the emotional state of men shortly after their infertility was diagnosed rather than looking at it during the course of treatment. The study showed that social stress, marital stress, coping effort and physical stress all increased over time and mental health decreased. But of most interest were that all the men, regardless of the reason for the infertility, suffered equally.

The above mentioned studies have all supported the identified perception level in the investigation carried out. It can hence be discussed in the context of the study variable that infertility is multidimensional in its occurrence. The perception score for physiological perception is 48.3%, psychological perception is 52.8% and sociological perception is 49.3%. The overall perception score is 50.8%. Hence the investigator concludes that infertile men are having maximum perception in psychological perception (52.8%) and minimum perception in physiological perception (48.3%). Table no.6 shows the infertile males level of perception. 9.3% of the infertile males having no perception, 30% of them having mild perception, 54.7% of them having moderate perception and 6% of them having severe perception.

(ii)The second objective of the study was to assess the acceptance of treatment by infertile men

Infertile males are having more acceptance in these aspects: regular to the treatment (37.3%), take break with one treatment option and then continue with other (32.7%), encouraged by your family members (12.7%). Table 9 shows each domain wise percentage of acceptances among infertile males. They are having maximum acceptance in taking a break (50.3%) and minimum score in paralleling (45.7%). Table no.10 shows the infertile males level of acceptance. 6.7% of the infertile males are regular, 46% of them are less irregular, 43.3% of them are moderate irregular and 4% of them are highly irregular.

In the year 1992 ***Blenner*** conducted in-depth interviews of 25 infertile couples covering the full range of infertility etiologies and treatments were conducted in this qualitative study. Professional competence, sensitivity and environmental comfort acted as mediators increasing or decreasing treatment stress. In addition, couples individually or collectively action or mental strategies to mitigate stress. High stress, lack of hope, and frustrations led to contemplation of terminating treatment.

(iii)The third objective of the study was to find out the association between perceptions and selected demographic variables.

Table no 12 shows that association between infertile males' level of perception and their demographic variables.More educated, who are completed secondary level (49) and higher secondary (54), more infertile period that is 5-8yrs and more years of treatment (4years) are significantly associated with level of perception. Hence the hypothesis one was accepted.

Chaise & Limst, 2000 USA had conducted a case control study on "factors associated with male infertility" in 218 infertile and 240 fertile men. The significant factors predicting infertility were smoking, density of sperm, and viability of sperm. Smoking increased the odds of being infertile. Higher sperm counts and larger percentage of viable sperm decreases the odds of infertility, density of sperm and the viability of sperm are significant predictors for infertility among men.

Olivia.A & Spira.A 2001, U.K. Had conducted a study on "contribution of environmental factors to the risk of male infertility" was conducted with 225 male partners. Emotional factors may negatively affect male infertility. The more obvious effect of the emotional stress in infertility places on male is the occurrence of impotence. Infertility is frequently perceived by the couple as an emotional strain, and counselling may prove helpful.

Li Y, Lin H et al., 2010 conducted a study on "Association between socio-psycho-behavioral factors and male semen quality". These results indicated that health programs focusing on lifestyle and psychological health would be helpful for male reproductive health.

(iv) The fourth objective of the study was to find out the association between acceptance of treatment by infertile men and selected demographic variables.

Table no 13 shows the association between infertile males' level of acceptance and their demographic variables. More income (>4000), more infertile period (2-4years) and late marriages (31-35years) are significantly

associated with level of acceptance. Hence the hypothesis two was accepted.

Dyer et al., (2004) had done a study on "Experiences, reproductive health knowledge, and treatment seeking behavior among men suffering from couple infertility in South Africa". The study explores reproductive health knowledge, treatment seeking behavior and experience related to involuntary childless in men suffering from couple infertility. They concluded that the findings will improve our understanding of reproductive health needs of men suffering from couple infertility in Africa. This understanding is essential for effective integration of male partners in to modern infertility management.

The investigator findings were similar to these study findings as they also proved that there exists a relation between selected demographic variables and perceptions and acceptance of treatment by males. The above mentioned studies serve as evidence that selected perceptions and acceptance are related either directly or indirectly to infertility.

CHAPTER – VI
6.0 SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 SUMMARY

In this chapter, the summary of the study, conclusion, the implication to nursing practice and the recommendation for the further study were presented. Infertility is becoming more and more an increasing issue in current scenario. In general, the man's reaction to infertility has been viewed as taking less of an emotional toll than his partner's. His reaction to his own infertility is often construed as interdependent with his partner's. Thus if she is coping well, he will follow accordingly. However, if she is having a difficult time, then his emotional stability will be compromised. He is often primarily delegated to the role of hand-holder, in charge of providing support for his partner during her grieving process. Little room is left for dealing with his own feelings of loss and sadness. This conforms to society's gender expectations, in which men are not given permission to express deep feelings of loss; on the contrary, they are encouraged to suppress emotions. Thus, society and the medical profession combined inadvertently conspire to ignore or underestimate the man's responsibility and role in the infertility process.

The current study is aimed to "Assess the perception and acceptance of treatment for impaired fertility among males attending Infertility Clinic at IOG, Chennai-8".

The main objectives of the study were

1) Assess the perception experienced by infertile men.

2) Assess the acceptance of treatment by infertile men.

3) Find out the association between perceptions and selected demographic variables.

4) Find out the association between acceptance of treatment by infertile men and selected demographic variables.

The data was collected in a period of four weeks during 29th August 2011 to 29th September 2011. One hundred and fifty samples were selected by convenient sampling technique and structured interview schedule was used to collect data. The statistical analysis was done using percentage, mean, standard deviation and Pearson Chi-Square tests. The findings were discussed based on the objectives of the study.

6.2 MAJOR FINDINGS OF THE STUDY

FINDINGS RELATED TO THEIR PERCEPTIONS

Physiological Perceptions

1) Majority of the subjects (65%) feel easily fatigue.

2) Majority of the subjects (59%) experience body pain and tension headache.

3) Majority of the subjects (48%) feels that they have reduced their weight.

4) Majority of the subjects (46%) has same sexual desire as before the diagnosis of infertility.

Psychological Perceptions

1) Majority of the subjects (61%) has sleep disturbance, feels that infertility is curse from God and has satisfaction in their sexual life.

2) Majority of the subjects (59%) worried about their future.

3) Majority of the subjects (58%) get psychological support from their partner.

4) Majority of the subjects (57%) felt guilty about not giving birth yet.

Sociological Perceptions

1) Majority of the subjects (59%) receive psychological support from their family members.

2) Majority of the subjects (57%) feel that they have been treated with respect.

3) Majority of the subjects (56%) have accepted that their neighbours and relatives are visiting their house.

4) Majority of the subjects (50%) have restricted their pleasure trips due to this problem.

Hence they have maximum score in psychological (53%) and minimum score in physiological perceptions (48%).

FINDINGS RELATED TO ACCEPTANCE OF TREATMENT

Sequential

1) Majority f the subjects (73%) have been regular to their treatment.

2) Majority of the subjects (46%) felt that duration of the treatment made them to exhaust before considering another treatment.

3) Majority of the subjects (45%) have exhausted with one option before considering another type of treatment.

Back Tracking

1) Majority of the subjects (51%) have encouraged by their family member to retry the treatment with new physician.

2) Majority of the subjects (50%) have felt retrying the treatment with new physician gives satisfaction for their infertility treatment.

3) Majority of the subjects (49%) retried the treatment with the same physician.

Taking a Break

1) Majority of the subjects (67%) took break with one treatment option and then continued with same treatment.

2) Majority of the subjects (48%) had the idea of adopting the baby.

3) Majority of the subjects (46%) withdrew from their treatment before completion, broke with one treatment option then continued with other treatment, took break with one treatment option and then continued with same treatment.

Getting Stuck

1) Majority of the subjects (49%) felt that cost of the treatment made them to withdraw from the treatment.

2) Majority of the subjects (46%) felt that the duration and causes of infertility made them to withdraw from the treatment.

3) Majority of the subjects (44%) felt that failure of the treatment and investigations of the treatment made them to withdraw and stuck with the treatment.

Paralleling

1) Majority of the subjects (47%) tried with treatment simultaneously with another physician.

2) Majority of the subjects (46%) thought taking multiple treatment options help them to conceive and tried multiple treatment options simultaneously.

3) Majority of the subjects (45%) have tried with other treatment regimen such as Siddha or Ayurvedha and tried one treatment option simultaneously with any other methods of treatment.

Hence they have maximum acceptance in taking a break (50%) and minimum acceptance in paralleling (45.7%).

ASSOCIATION BETWEEN PERCEPTIONS AND SELECTED DEMOGRAPHIC VARIABLES

Men with infertility were at prone for developing perceptions in the aspect of physiological, psychological and sociological aspects.

Majority of the subjects (36%) had secondary education, 47% of them are in between 2-4years of infertility period and 57% of them are taking 4years of treatment for infertility that is more educated, more infertile period and more years of treatment are significantly associated with level of perception.

ASSOCIATION BETWEEN ACCEPTANCE OF TREATMENT AND SELECTED DEMOGRAPHIC VARIABLES

Acceptance of treatment is significantly associated with male infertility.

Men with monthly income of Rs.1000-2000 were highly irregular (16%) and moderate irregular (53%), age at marriage between 20-25yrs had highly irregular (7.1%) and moderate irregular (50%) and the period of infertility above 12 years were highly irregular (21.7%) and between 9-12 years period of infertility men had moderate irregular (52.4%) in acceptance of treatment.

6.3 CONCLUSION

Assessing how well a person or couple is coping with infertility is an essential part of the domain of nursing, and helping people to cope with emotional and psychosocial aspects of infertility. Infertility is a life crisis with invisible loss and its consequences are manifold. Childless women have experienced stigma and isolation. Infertility can threaten a woman's identity, status and economic security and consequently, be a major source of anxiety leading to lowered self esteem and a sense of unworthiness. Although perceptions of men's role and attitudes may be shifting, particularly in the upper and middle classes, bearing a child still remains an important factor in the socio-economic well being of the most Indian Men.

The study concluded that there is a moderate positive relationship between perception and acceptance of treatment by impaired male fertility. They were significantly associated with certain demographic variables. More educated, period of infertility and more years of treatment are significantly associated with level of perception whereas more income, period of

infertility and age at marriage are significantly associated with level of acceptance.

6.4 IMPLICATIONS

The findings of the study are related to the nursing fields. The implications of this study could be discussed in 4 areas namely nursing practice, nursing administration, nursing education and nursing research.

NURSING PRACTICE

- As members of health care professional, nurses must equip themselves with adequate understanding of the clients with stress, expectations and coming from various socio economic backgrounds.

- Nurses are accountable in providing a quality and holistic patient care. This is achieved only if nurses have taken keen interest in identifying the various areas of stress which affect their health.

- The findings of the study can be used by nurse to improve the physical and mental health of the infertile men. This finding will also help nurses in counseling the couples in the outpatient department.

NURSING ADMINISTRATION

- The findings of the study could be utilized as a basis for the nurse administrators in planning for necessary interventions in minimizing the perceptions. Thus it would enable every member of the organization to provide a quality care for the infertile clients.

- Nurse administrators can start training volunteers and in-service education for the staff so that they can provide specialized care for the infertile clients and their families.

- Nurse administrators can start guidance and counselling centres attached to hospitals arising to help infertile couples.

- Nurse administrators should provide the necessary physical facilities in the infertility clinics for examining, counselling and teaching infertile

men on various treatment methods.

- Good supervisory arrangement is necessary to ensure that the practicing nurses are effectively implementing the educational programmes and also ensure that the infertile men are effectively taking treatment.

NURSING EDUCATION

The findings could be served as a guideline for the nurse educators to plan in service education programmes on

- Treatment modalities
- Counselling programmes
- Interventions to improve the quality of life of infertile clients and the facilities to be available in community organizations.
- This information will help the nurses to minimize the perceptions which affect the infertile men.

NURSING RESEARCH

The essence of research is to build knowledge in nursing as it is an evolving profession.

- The effectiveness of the studies in the research field is verified by its ability to be practiced by the nurses in the clinical settings.
- The findings of the study will help the professional nurses and nursing students to develop inquiry by procuring a base.
- This study helps the nurse researcher to develop insight to assess the perceptions and acceptance of treatment by infertile men.

6.5 RECOMMENDATIONS OF THE FURTHER STUDY

On the basis of the study, the following recommendations are made for further study.

- A similar study can be done on a larger sample for broader generalization.
- A similar study can be done to identify the perceived perceptions affecting the spouse of the infertile men.
- A comparative study can be done to find out the perceptions among infertile women with primary and secondary infertility.
- A study can be done to assess the stress and the coping mechanism of infertile couples.
- A longitudinal study can be done including the quality life of infertile men.
- A study can be done to assess the stress of infertile men and women undergoing different treatment modalities.
- An interventional study to identify the effectiveness of meditation in reducing stress among infertile couples.

MERITS OF THE STUDY

1) The present study identified the relationship between the perceptions and acceptance of treatment by impaired male fertility.

2) Studies assessing perceptions and acceptance in our set-up is quiet rare.

3) Questionnaire on male infertility suits our culture.

6.6 LIMITATIONS

1) The study was restricted to a short duration.

2) The findings cannot be generalized because of small samples.

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Part -I

DEMOGRAPHIC PROFILE

Structured Questionnaire Schedule to assess the demographic variables like Age, Education and Occupation…etc.

1**. Age**

a) 20 – 25 yrs

b) 26 – 30 Yrs

c) 31 – 35 Yrs

d) 36 – 40 Yrs

2. Education

a) No formal education

b) Primary

c) Secondary

d) Higher secondary

e) Graduate/post graduate

3. Occupation regarding

a) Employed

b) Unemployed

If yes, specify the nature of employment

4**. Income Monthly**

a) 1000-2000

b) 2001-3000

c) 3001-4,000

d) >4,000

5. **Type of family**
   a) Nuclear family
   b) Joint family
   c) Extended family
6. **Age at marriage**
   a) 20-25yrs
   b) 26-30yrs
   c) 31-35yrs
   d) 36-40yrs
7. **Period of infertility**
   a) 2 – 4 Yrs
   b) 5 – 8 Yrs
   c) 9 – 12 Yrs
   d) > 12 Yrs

8. **Any habit of**
   a) smoking
   b) alcohol
   c) Pan users
   d) Drugs
9. **Use of contraceptives**
   a) Yes
   b) No

10. **Years of treatment taken for infertility**
   a) 2yrs
   b) 4yrs
   c) 6yrs
   d) >6yrs

PART II

SECTION – A

PHYSIOLOGICAL PERCEPTIONS RELATED TO INFERTILITY

S.No	**PERCEPTIONS**	No	If Yes		
			Rarely	occasionally	Always
1	Do you have less appetite?				
2	Do you feel that you have reduced your weight?				
3	Do you suffer from body pain? (back ache, chest pain)				
4	Do you have tension head ache?				
5	Do you feel easily fatigue?				
6	Do you suffer from any problem of ulcer? (gastric)				
7	Do you have same sexual desire as before?				

SECTION-B

PSYCHOLOGICAL PERCEPTIONS RELATED TO INFERTILITY

S.No	**PERCEPTIONS**	No	If Yes		
			Rarely	occasionally	Always
1	Do you get angry very often?				
2	Do you feel less interest in life?				
3	Do you have sleep disturbance?				
4	Do you have concentration problem at work?				
5	Do you feel guilty about not giving birth yet?				
6	Are you worried about your future?				
7	Do you have crying spells?				
8	Are you frustrated in your life?				
9	Do you feel worthless of yourself at any time?				
10	Do you feel loneliness?				
11	Are you having problem in decision making?				
12	Do you feel it is curse from God?				
13	Do you lose your temper often?				
14	Are you satisfied in sexual relationship with your partner?				
15	Do you get psychological support from your partner?				

SECTION-C

SOCIOLOGICAL PERCEPTIONS RELATED TO INFERTILITY

S.No	Perceptions	No	If Yes		
			Rarely	occasionally	Always
1	Do you join in family function as before?				
2	Do you face any problems with in laws(ill treatment) ?				
3	Do you quarrel or fight with your partner regarding this issue?				
4	Do you receive psychological support from your family?				
5	Does your partner extend support financially?				
6	Do you receive financial support from your family members for treatment?				
7	Are you treated with respect by your colleague/relatives and family members in the house?				
8	Are your relatives and neighbors visiting your house as usual?				
9	Have you restricted your pleasure trips due to this problem?				

Part- III

Structured Questionnaire Schedule for assessing the acceptance of Treatment by infertile men.

S.No		**Most of the time**	**Sometime**	**Rarely**	**Never**
1	**Sequential tracking** Have you been regular to the treatment advised by the physician for your infertility?				
2	Did you exhaust with one option before considering another type of treatment?				
3	Did you exhaust with one option before completing the treatment?				
4	Do you feel that duration of the treatment made you to exhaust with one treatment before considering other treatment?				
5	Do you feel that failure of the treatment made you to exhaust with one treatment before considering another kind of treatment?				
6	**Back tracking** Did you retry the treatment with new physician?				
7	Did you retry the treatment with the same physician?				
8	Have you felt retrying the treatment with new physician gives satisfaction for the infertility treatment?				
9	Have you been encouraged by your family member to retry the treatment with new physician?				
10	Have you been encouraged by your spouse to retry the treatment with same physician?				
	Taking a break Did you take break for a while and then				

11	continue with the treatment?				
12	Did you withdraw from the treatment before completion?				
13	Did you break with one treatment option then continue with other treatment?				
14	Did you take break with one treatment option and then continue with same treatment?				
15	Did you have the idea of adopting the baby?				
16	**Getting stuck** Did the failure of the treatment made you to withdraw from the treatment?				
17	Did the cost of the treatment made you to withdraw from the treatment?				
18	Did the investigations of the treatment made you to struck with the treatment?				
19	Have you felt the duration of infertility made you to withdraw from the treatment?				
20	Do you feel that causes of the infertility made you to withdraw from the treatment?				
21	**Paralleling** Do you try with multiple treatment options simultaneously?				
22	Do you try with other treatment regimen such as Siddha or Ayurvedha?				
23	Have you thought taking multiple options help you to conceive?				
24	Do you try one treatment option simultaneously with any other methods of treatment?				
25	Do you try with treatment simultaneously with any other physician?				

நேர்முக காணல் படிவம்

பகுதி-1

புள்ளி விவர ஆய்வு

1) வயது (வருடங்களில்)

அ) 20-25 ☐

ஆ) 26-30 ☐

இ) 31-35 ☐

ஈ) 36-40 ☐

2) கல்வித் தகுதி

அ) பள்ளி சேராக் கல்வி ☐

ஆ) ஆரம்பக் கல்வி ☐

இ) நடுநிலைக் கல்வி ☐

ஈ) உயர்நிலைக் கல்வி ☐

3) பணியின் நிலை

அ) பணிபுரிபவர் ☐

ஆ) பணிபுரியாதவர் ☐

இ) பணிபுரிபவரின் பணியின் விவரம் ☐

4) மாத வருமானம்

அ) ரூ.1000- 2000 ☐

ஆ) ரூ.2001 - 3000 ☐

இ) ரூ.3001 - 4000 ☐

ஈ) ரூ.4000க்கு மேல் ☐

5) குடும்ப வகை

அ) தனிக்குடும்பம் ☐

ஆ) கூட்டுக்குடும்பம் ☐

இ) இணைந்த குடும்பம் ☐

6) திருமணத்தின்போது வயது (வருடங்களில்)

அ) 20-25 ☐

ஆ) 26-30 ☐

இ) 31-35 ☐

ஈ) 36-40 ☐

7) மலட்டுத்தன்மையின் வருடங்கள்

அ) 2 - 4 ☐

ஆ) 5 - 8 ☐

இ) 9 - 12 ☐

ஈ) 12 வருடங்களுக்கு மேல் ☐

8) பழக்கம்

அ) சிகரெட் பிடிப்பது ☐

ஆ) மது அருந்துவது ☐

இ) பான்பராக் போடுவது ☐

ஈ) மருந்துகள் உட்கொள்வது ☐

9) கருத்தடை சாதனை உபயோகம்

அ) ஆம் ☐

ஆ) இல்லை ☐

10) எத்தனை கால வருடமாக உங்கள் மலட்டுத்தன்மைக்கு சிகிச்சை எடுத்துக் கொண்டீர்கள்?

அ) 2 வருடம் ☐

ஆ) 6 வருடம் ☐

இ) 4 வருடம் ☐

ஈ) 6 வருடங்களுக்கு மேல் ☐

பகுதி-2
பிரிவு- அ

மலட்டுத்தன்மை சார்ந்த உடற்செயலில் பிரச்சனைகள்

வ. எண்		இல்லை	ஆம் எனில்		
			குறைந்த	சமாரான	மிக அதிகமான
1.	உங்களுக்கு பசியின்மை உள்ளதா?				
2.	உங்கள் எடை குறைந்துவிட்டதாக உணர்கிறீர்களா?				
3.	உடம்பு வலி ஏற்படுவதுண்டா? (முதுகு வலி, நெஞ்சுவலி)				
4.	மன அழுத்தத்தால் ஏற்படும் தலைவலியால் அவதிப்படுகிறீர்களா?				
5.	உடற்சோர்வு ஏற்படுவதுண்டா?				
6.	வயிற்றுப்புண் அறிகுறி உள்ளதா?				
7.	உடலுறவில் நாட்டம் குறைந்து இருப்பதாக உணர்கிறீர்களா?				

பிரிவு–ஆ

மலட்டுத்தன்மை சார்ந்த மனவியல் பிரச்சனைகள்

வ. எண்		இல்லை	ஆம் எனில்		
			குறைந்த	சமானான	மிக அதிகமான
1.	இந்தப் பிரச்சனைகளுக்காக அடிக்கடி கோபப்படுவதுண்டா?				
2.	வாழ்க்கையில் விருப்பம் குறைந்துள்ளதா?				
3.	தூக்கம் தொடர்பான பிரச்சனை ஏற்படுவதுண்டா?				
4.	உங்கள் அன்றாட வேலைகளில் கவனம் செலுத்துவது கடினமாக உள்ளதா?				
5.	எதிர்காலத்தை குறித்து கவனை கொள்கிறீர்களா?				
6.	இன்னும் குழந்தை பெறாமல் இருப்பது குறித்த குற்ற உணர்வு உண்டா?				
7.	இந்தப் பிரச்சனையை நினைத்து அழுவதுண்டா?				
8.	வாழ்க்கையில் சோர்வு அடிக்கடி ஏற்படுவதுண்டா?				
9.	நான் பிரயோஜனம் இல்லாதவள் என்று உணர்கிறீர்களா?				
10.	நீங்கள் தனிமையாக விடப்பட்டதுபோல எப்போதாவது நினைத்ததுண்டா?				
11.	இந்தப் பிரச்சனைகளின் காரணமாக எந்த ஒரு பிரச்சனைக்கும் சரியான தீர்வு எடுக்க முடியாமல் இருக்கிறீர்களா?				
12.	கடவுளின் சாபமோ என்று கருதுவதுண்டா?				
13.	சீக்கிரமாக வெறுப்பு அல்லது கோபப்பட்டு விடுகிறீர்களா?				
14.	உங்கள் தாம்பத்ய உறவில் திருப்தியாக உள்ளீர்களா?				
15.	உங்கள் வாழ்க்கைத்துணையிடம் இருந்து ஆறுதலான வார்த்தைகள் உண்டா?				

பிரிவு-இ

மலட்டுத்தன்மை சார்ந்த சமுதாய பிரச்சனைகள்

வ. எண்		இல்லை	ஆம் எனில்		
			குறைந்த	சமானான	மிக அதிகமான
1.	குடும்ப விழாக்களில் கலந்துகொள்வதற்கு தயக்கமாக உள்ளதா?				
2.	மாமனார், மாமியார் உங்களை புண்படுத்தும்படியாக பேசியதுண்டா?				
3.	இந்தப் பிரச்சனையில் நிமித்தம் உங்கள் இருவருக்கும் சண்டை ஏற்படுகிறதா?				
4.	உங்கள் மனைவி உங்களுக்கு ஆறுதலாய் பேசுவார்களா?				
5.	மருத்துவத் தேவைகளுக்கு உங்கள் மனைவி பண உதவி செய்கிறாரா?				
6.	குடும்ப நபர்களிடம் இருந்து மருத்துவ தேவைக்கு பண உதவி கிடைக்கிறதா?				
7.	உங்கள் குடும்பத்தினர், நண்பர்கள் மற்றும் உறவினர்களால் எப்போதும் போல் மதிப்பிடுகிறார்களா?				
8.	எப்போதும்போல் உறவினர் மற்றும் நண்பர்கள் உங்கள் வீட்டிற்கு வந்து செல்கின்றார்களா?				
9.	இந்தப் பிரச்சனையினால் உல்லாசப் பயணங்களை குறைத்துக்கொண்டு இருக்கிறீர்களா?				

சரியான முடிவை கட்டத்திற்குள் (✓) நிரப்பவும்

வ. எண்		அதிக நேரம்	சில நேரம்	எப்போதாவது	எப்போதும் இல்லை
1.	உங்களுடைய மலட்டுத்தன்மைக்கு மருத்துவரின் ஆலோசனைப்படி தொடர்ந்து சிகிச்சை எடுத்துக்கொள்கிறீர்களா?				
2.	தாய்மை அடைவதற்கான வழிகளில் ஒன்றில் இருந்து மற்றொன்றுக்கு போகும் முன் மனம் தளர்ந்து விடுகிறீர்களா?				
3.	தாய்மை அடைவதற்கான வழியில் சிகிச்சை பெறும்போது அந்த சிகிச்சை நிறைவுபெறும் முன் தளர்ச்சி அடைகிறீர்களா?				
4.	மரபு வழியைப் பற்றி சிந்திக்காமல் சிகிச்சை தவறானதற்கு இதில் ஒன்றைத் தேர்ந்தெடுத்ததுதான் காரணம் என்று உணர்கிறீர்களா?				
5.	மரபு வழியை பற்றி சிந்திக்காமல் சிகிச்சைக்குறிய காலம் இதில் ஏதேனும் ஒரு சிகிச்சையை மாற்றிக்கொள்ள உதவியதா?				
6.	இந்த சிகிச்சை வேறு புதிய மருத்துவர் மூலம் மேற்கொள்ள விரும்புகிறீர்களா?				
7.	அதே மருத்துவர் மூலம் மட்டுமே தொடர விரும்புகிறீர்களா?				
8.	கருவுறாமைக்கு புதிய மருத்துவர் மூலம் நீங்கள் எடுத்துகொண்ட சிகிச்சை உங்களுக்குத் திருப்தியளிக்கிறதா?				

வ. எண்		அதிக நேரம்	சில நேரம்	எப்போதாவது	எப்போதும் இல்லை
9.	புதிய மருத்துவரிடம் சிகிச்சையைப் பெறுவதை உங்கள் மனைவி ஊக்குவிக்கிறார்களா?				
10.	அதே மருத்துவரிடம் சிகிச்சை பெறுவதை உங்கள் குடும்பத்தார் ஊக்குவிக்கிறார்களா?				
11.	நீண்ட இடைவெளிவிட்டு சிகிச்சையைத் தொடர்கிறீர்களா?				
12.	சிகிச்சை முடிவடையும் முன் இடையில் நிறுத்திவிட்டீர்களா?				
13.	முதல் சிகிச்சையை நிறுத்திவிட்டு மீண்டும் அதே சிகிச்சையைத் தொடர்கிறீர்களா?				
14.	முதல் சிகிச்சையை இடையில் நிறுத்திவிட்டு மீண்டும் அதே சிகிச்சையை தொடர்கிறீர்களா?				
15.	பொருத்தமான முறையை மேற்கொள்ளவில்லை என்பதை மீண்டும் அதே சிகிச்சையை தொடர்கிறீர்களா?				
16.	சிகிச்சை தோல்வி அடைந்ததால் அதிலிருந்து விடுபடச் செய்ததா?				
17.	சிகிச்சைக்குறிய செலவு அதிகமானதால் அதிலிருந்து விடுபடச் செய்ததா?				
18.	சிகிச்சையில் ஏற்பட்ட கண்டுபிடிப்புகளால் சிகிச்சையில் தடை ஏற்பட்டதா?				
19.	கருவுறாமைக்குரிய காலக்கெடு உங்களுக்கு சிகிச்சையை தொடர முடியாமல் செய்ததா?				

வ. எண்		அதிக நேரம்	சில நேரம்	எப்போதாவது	எப்போதும் இல்லை
20.	கருவுறாமைக்குரிய காரணங்கள் உங்களுக்கு சிகிச்சையைத் தொடர முடியாது என்ற உணர்வு ஏற்படுகிறதா?				
21.	அதிகமான சிகிச்சைகளை ஒரே நேரத்தில் மேற்கொண்டீர்களா?				
22.	சித்த ஆயுர்வேதம் போன்ற மாற்று சிகிச்சைகளை முயற்சி செய்தீர்களா?				
23.	நீங்கள் மேற்கொண்ட அதிகப்படியான முறைகள் நீங்கள் நீங்கள் கருத்தரிக்க உதவியதா?				
24.	ஒரே சிகிச்சையை அதே நேரத்தில் வேறு விதமான சிகிச்சை முறையில் மேற்கொண்டீர்களா?				
25.	ஒரே சிகிச்சையை அதே நேரத்தில் வேறு மருத்துவர் மூலம் மேற்கொண்டீர்களா?				